



Max Planck Institute for the Study of  
Religious and Ethnic Diversity

Max-Planck-Institut zur Erforschung multireligiöser  
und multiethnischer Gesellschaften

*MMG Working Paper 11-11* • ISSN 2192-2357

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Trust talk and alienable talk in healing:  
a problem of medical diversity\*



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MMG Working Paper 11-11

Max-Planck-Institut zur Erforschung multireligiöser und multiethnischer Gesellschaften,  
*Max Planck Institute for the Study of Religious and Ethnic Diversity*  
Göttingen

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ISSN 2192-2357 (MMG Working Papers Print)

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## Abstract

Co-existing medical traditions operate at different levels of scale. In rural eastern Africa there are diviners and herbalists whose clients are drawn from the immediate neighbourhood. Some develop healing reputations more widely over a region or nation, sometimes with prophetic and witch-finding powers. Biomedical clinics and hospitals are also interlinked regionally, nationally and internationally. Patients or carers may seek healthcare by moving through these different levels, sometimes beginning with a neighbourhood healer and sometimes trying out different therapies simultaneously. Sicknesses and misfortunes are often first discussed within a family or homestead, with concern for the victim extending to all its members. The talk is based on assumed trust among its members. But, if unresolved, the affliction may trigger a crisis which breaks the trust, so that healers beyond the neighbourhood are sought, whether prophetic/witch-finding or biomedical. Taken out of the context of family and homestead intimacy, the talk blames the ailment on the malevolence or negligence of individuals in the community. Talk about sickness among sufferers and between them and healers, is thus transformed from that which seeks resolution in amity to that which seeks culpability and, sometimes, retribution. A similar process of sickness talk changing through its appropriation by wider scale and more powerful medical authority occurs also in western biomedical hospitals and clinics.

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## Trust in crisis

Medical crises provoke talk as well as action. Ailments sometimes bring people together who trust each other's advice, but at other times divide them along the lines of discrepant and unsuccessful explanations and attempted cure. Talk about sickness may then oscillate between trust and its alienation. This paper asks how different actors in medical crises fit into this spectrum of alternating trust and alienation.

First, however, we must examine the notion of trust itself. Trust is a notion that most obviously finds social relevance and perhaps origin in systems of trade and credit. We speak also of political, professional and interpersonal trust. There are financial 'Trusts', which operate at a distance from clients. While trust between friends is expressed as part of their intimacy, that of patients and clients for doctors or lawyers is not normally intimate. Instead, it is expressed in the idiom of interpersonal exchange. The view that politicians can be assessed according to their trustworthiness is probably a feature of representational and/or 'democratic' politics, especially its modern versions, in which voting or choice of appointments are practiced. While different institutionally, historically, culturally, and in the social distance between the trusted and the trusting, all depictions of 'trust' in the English language at least, are premised on the idea that material and/or emotional investment will be repaid. Not all languages may have a word that translates trust, and that between friends may be thought and spoken of quite differently from that between traders who work on credit. But I speculate that, despite overlapping connotations, a version of the concept exists everywhere or has existed in practice, even if only through trade and alliances, and that it can be spoken of in different ways, even if not by a single term. It is indeed difficult to imagine any society or on-going group managing its affairs without a notion of trust in at least one of the above senses (see Shipton 2007).

But how is this common, polythetic concept affected by late modern, large population movements, densities, and socio-cultural diversities that are supposedly taking place on a greater global scale and are more rapidly communicated than ever before? Dunbar's work (2010) on so-called friendship networks on the internet suggests that, while most contacts are too fleeting or peripheral to require trust in any sustained sense, a core of relationships continue to work according to the concept in some form, and that the actual number of people who would see themselves as able to trust each other in some degree, is much the same as before the internet came into being. So much for the scale. However, there remains the question of how much socio-cultural variation in the idea of trustworthiness has developed in the last couple

of generations or so. How is the discourse of trust affected by the newly emerging socio-cultural super-diversity of persons, to which Vertovec (2007) and others draw attention? Are there some social groups which resist socio-cultural diversification more than others, and how does such variation affect the place of trust in medical discourse?<sup>1</sup>

One area that can be usefully be explored here is that of the patient-healer/doctor relationship. This is because trust is to some extent intrinsic to this relationship: you do not normally entrust your or your family's bodily and mental condition to someone who is not regarded as competent to treat it. Moreover, by placing the focus on particular ethnographic areas (here mainly east and central Africa), we can better see how modern circumstances may alter, or perhaps reinforce, notions of trust or convert them into some other expression.

Medical crises are a good starting-point. For a particular family, a child's debilitating sickness is a serious crisis in the sense of requiring urgent attention. Crisis in the medical sense may mean that the child is having to reach and survive the peak of a fever in order gradually to be restored to health. The term also refers to situations beyond the family. Indeed, another common idea of medical crisis is that of an epidemic, perhaps becoming endemic and perhaps also developing into a pandemic. These terms have been used in recent years by the media in particular to refer to fears associated not just with HIV/AIDS but with various forms of influenza (avian flu, swine flu and even Creutzfeld-Jakob disease, which is linked to the so-called mad cow disease, and so on). Regional health crises occurring in, say, parts of Africa include outbreaks of cholera and an increase in malaria or cases of dengedenge. This is to take a macro-view of medical crisis and to focus on its potentially global spread or containment. The counterpart is to consider the concept of crisis both from a local perspective and as an aspect of healthcare relationships. For it is ultimately in the interactions between sufferers, those around them and those charged with caring for them, that disruptions in communication, understanding and trust are likely to be experienced on a day to day basis and to be regarded as crises for the participants themselves. For instance, what do you do and how do you feel if you fall out with your doctor or find the hospital in which you are a patient intolerable, or have lost confidence in these and other healing traditions? Such sentiments of alienation may be regarded as precipitated by a crisis, such as a wrong diagnosis, or indeed as the crisis itself. In a world of medical diversity in which alternative healing traditions may be used and the traditions themselves borrow from each other, sufferers may in anguish seek the different possible cures seemingly available, failure of which deep-



ens the sense of despair and personal and interpersonal crisis. Uncertainty is the single most emotionally agitating feature of any healing tradition (see Whyte 1997). It shapes peoples' perceptions of the various healing establishments and authorities and so provides an unpredictable backdrop to the popular assumption of medical expertise. Healers know things and can be counted on, for otherwise why go to them? But they sometimes make mistakes and do not always deliver patients from suffering. Despite such uncertainty in the profile of healing as a vital human activity, doctors and their patients are depicted within particular traditions as occupying particular roles with respect to one another. This reveals the tension not only between the hope of cure and the fear of its failure, but also between the alternative approaches that make up healing diversity. Paradoxically trust rests on, but also tries to surmount uncertainty.

In medical anthropology, there has been some attempt to capture the diversity within as well as between different traditions, including the kinds of breakdowns that result in interpersonal crises and loss of trust. Thus, the relationship between healers or doctors and their patients has been characterized in a variety of ways, ranging from 'encounter', (between, for example, biomedical general practitioner (GP) and patient ((Hahn and Gaines 1985)), to 'negotiation' (as in the exchange between African diviner-herbalist and client (Parkin 1979; see also Kleinman 1988:239-244)). The encounter normally presupposes a hierarchy of power in favour of the healer, to whom the patient is subordinate and defers. Negotiations do not rule out the ascendancy and superior knowledge and skills of the healer but allow for the possibility that the patient may question the healer's judgment and perhaps bring some of his/her own knowledge to the diagnosis. Some healer-patient relationships fall into neither of these categories and are based rather on a non-discussed and mutual acknowledgement of roles leading to cure, an example being that of the Muslim *pir* in Pakistan, who diagnoses quickly and with minimal communication with the patient, and transmits the curative power or blessing from God to the patient (Ewing 1984).

Encounters can soften up, so to speak, and become negotiations. For instance, biomedical GPs occasionally have to deal with patients whose medical knowledge is sufficient for them to challenge the diagnosis and curative suggestions made. The reverse may occur: the shaman's authority in a particular case becomes unquestioned, so that negotiation with his/her client is reduced. Sometimes neither the shaman's nor the patient's authority is viewed as paramount. In healer-patient relationships of the *pir*-type, neither the healer nor the patient is likely to challenge or negotiate with God, but sometimes a relationship of this kind, conducted through a human

intermediary such as a priest or a diviner, does allow for negotiation, and many cases of spirit possession and shamanism have this feature of supplication by a human to a divinity.

Negotiation and unquestioned acceptance are then best seen as points on a possible continuum along which healer-patient relationships may fall, and as overlapping tendencies characterizing such relationships rather than as essential and fixed elements. A variable element in these different possibilities is the extent to which a hierarchy of power and competence is regarded by participants as being determinative of the communicative, informational and curative exchanges between healer and patient: the GP may, almost like God, be regarded in extreme cases as omniscient and not needing the patient's verbal input, while the African healer draws much of his/her understanding of the client's problem from knowledge of the latter's local community, sometimes extracting this directly from the client.

In areas of eastern Africa in which I have worked over a couple of generations, such distinctions of relationship type have in some cases become blurred over the years, but in others have continued as part of a resistance to medical diversification. Different local and global medical traditions sharing common spaces and coming within the purview of each other are thus sometimes demarcated from each other but may also overlap in procedure and ethos and become internally changed. Even in Euro-America there is nowadays greater acceptance within the biomedical establishment of publicly acknowledging the fallibility of GPs and hospitals, and the right of patients to participate questioningly in the dialogue, which departs from an older view of the doctor's diagnosis as being beyond question. Contrariwise, the greater professionalization of, say, African healers, (often through ancient guilds but also in partial imitation of modern biomedical associations), dissolves somewhat the traditionally more egalitarian relationship with patients. Has the apparent growth in the worldwide patient demand for, say, Ayurvedic and Chinese Traditional Medicine (CTM), brought about comparable variations in professional ethos (see Hsu 2009 for the prevalence of CTM in East Africa)? Has it altered the uncertainties on which trust paradoxically flourishes? An impression is that global medical diversity brings oscillations of encounter, negotiation and silent curative exchange within and between healer-patient relationships into healing traditions, and that it has the potential for changing the conditions of trust.

## Trust and alienation

I therefore propose a different heuristic contrast, which builds on that of encounter-negotiation-passive acceptance, but has more general applicability in health-seeking contexts, including but going beyond the idea of diagnostic and curative exchange as a hierarchy of power and competence. I go beyond the confines of the healer-patient relationship and into the wider field of talk or discussion about illness, disease and how healers respond to sickness and misfortune. I make a distinction between ‘trust talk’ and ‘alienable talk’. My observations here derive primarily from my own field-work experience in eastern Africa, primarily among the Giriama of Kenya, and it is then a question of whether and to what extent they are more widely prevalent.

For various practical and ethical reasons, I do not have recordings of the actual conversations that occur between people when they are confronted by and then discuss an illness or misfortune in their household or homestead. I do however have notes and memories of such events.

*A twelve year old Giriama boy's face suddenly swelled up, which I presume was an allergic reaction. His father talked to other members of the family and called in neighbour-friends and elders, who advised seeing a diviner. A few said it might be witchcraft and this was confirmed by the diviner later that day, who also pointed the family to a herbal doctor whose medicine reduced the swelling. The issue of who might be the responsible witch was not pursued in view of the rapid cure and boy's full return to health, and the whole matter passed over. The group of neighbourly and family advisers had acted together in amity, listening to and, on the face of it, trusting the sincerity of each other's advice. In the same homestead some months later, a two year old boy caught measles. Again, the same round of trusting advice was given, and the child began to respond well to a combination of herbal medicine, aspirin, sleep and his mother's care. But then a courier came with the urgent news that the mother's father had died. He lived some fifty miles away. It was imperative that the woman follow custom and see her father and attend his burial and funeral, which can last more than a week. However, child measles easily leads to complications, especially under conditions of inadequate care. The mother had no alternative but to take her child with her, it not being normal to leave a child with others while making a trip of so many days. But the journey was long and arduous over rough roads, that were hot, crowded, and had many changes, sometimes between bus and truck. The child rapidly became dehydrated, developed serious fever and died a few days after the mother reached her dead father's homestead. Mother and*

*child returned home for the child's burial. The earlier assembly of family and neighbours was joined by many others from around the locality, who argued with each other about how to go about what many considered to be a heinous and, taking into account the earlier case of illness, an evidently recurrent instance of witchcraft aimed at this homestead. Hints and innuendoes about possible, unnamed suspects were made, but these were not consistent and caused conflict between members of the group if they thought it could be interpreted that a close member of their own family, or even themselves, was being accused. Diviners or shamans were sought but their findings were not accepted by everyone and the child's father took it upon himself, against the advice of some elders but with the concurrence of others, to seek out a major witch-hunter/prophet famous in the region and nationally. The homestead and its immediate neighbourhood had by now become the site of intense fear, suspicion and even hatred, as old scores merged with the immediate problem of a possible local witchcraft menace.*

*In other cases of sickness, recourse may be made to a biomedical clinic or hospital as well as, and sometimes instead of, a senior diviner or shaman. This is more likely if the homestead head is Christian or Muslim and, possibly, has some school education. In the area of Giriama country where I worked, a local hospital was founded by the Church Missionary Society, which still has influence in the operation of the now government hospital. Also in the area is a more recently established Muslim clinic that was set up with Middle East funds.*

Trust talk may, then, occur between patient and healer or may be communal, with members of the community speaking from established roles and cooperating in a common search for reparation or remedy. Sometimes a remedy is indeed secured and trust is retained. However, this may not always be the case. A remedy remains elusive and, over time, the talk may become emotionally fraught and fragmented and threaten the very relationship or community on which trust is based.

Alienable talk is based on mistrust or the loss of trust. It may occur between healer and patient or the patient's representative. Alienable talk may, however, also result when persons in interaction with each other, as members of a community, are thrown into panic when trust talk breaks down or when they are suddenly and without warning confronted by an unexpected and apparently uncontrollable sickness or misfortune among them. Within a community the panic prompted by the crisis may take the form of cross-talk, in which different and contradictory suggestions, claims, accusations and counter-accusations are made about the adversity.

The talk has become fragmented and inconsistent among those who once trusted each other. As such it is vulnerable to capture by another medical authority, which is in a position to straighten out the conflicting talk and produce clear explanations and curative suggestions. Such authority may be other local healers, who are however often careful not to produce diagnoses and cures that appear to conflict and therefore compete with other healers in the locality. In rural areas a more likely appropriating medical authority is either a biomedical practitioner at a clinic or hospital, or one of the regional or national healer-prophets.<sup>2</sup>

While it is true that a few biomedical doctors have close relationships with particular families and so are able to retain or re-establish the egalitarian mode of trust talk, more commonly s/he is socially distant from those from whom they are consulted. A biomedical authority may then appeal to a wider rule-based procedure as giving them the legitimacy to take over the sickness event and gradually turn it into the property, so to speak, of established biomedical figures whose task it is to assuage the panic and pronounce on the nature of the sickness. They alienate the experience of the sickness event from the original sharers and convert it into judgments of cause, effect and repair. The trust talk had become alienable, with different viewpoints making the sickness case subject to the predations of competing and rival parties. The emotional expression characteristic of trust talk may then give way to judgment that is regarded as 'rational' and is codified according to biomedical criteria. It may also take the form of moral judgment, perhaps within a religious frame: thus, the sickness or pandemic is due to impiety, improper diet, sexuality or life-style. The alienated talk then becomes either rational-bureaucratic or religious formalistic and rhetoric.

As indicated in the case, the appropriating medical authority need not be biomedical. Indigenous healers-turned-prophets, sometimes called witchfinders and commonly found in Africa, take on large-scale problems of ill-health and general misfortune, and aim to 'cleanse' the community and its land of the affliction and its causes. Such prophet-like movements, not always witch-seeking, are usually cyclical, with new prophets or regional healers emerging every half generation or so, though there are also more enduring prophet institutions. Cults may build up around them (Schoffeleers 1979; Van Binsbergen 1981). There is a considerable early literature on African prophets and on so-called witchfinders, whose powers often include prophetic visionary predictions as well as cure, reparation, and calls for peace as well as war (e.g. Bond 1979; Brantley 1979; Douglas 1963; Goody 1957; Johnson 1994; Marwick 1950; Parkin 1968; Ranger 1966; 1975; Redmayne 1970; Richards 1935; Ward 1956; Willis 1968). Christianity may have denounced witchcraft beliefs however these were

often wrapped up in the ‘sins’ and ‘evils’ that needed to be cast out by church-based prophetic figures. Balandier’s early work (1955) on the Kimbanguist and Matswanist church-based prophetic movements in former French and Belgian Congo has most recently been explored by Ramon Sarro, who extends study of this continuing, modern phenomenon to Guinea, Guinea Bissau and Angola<sup>3</sup>. The figure of the Christian prophet in late modernity may well be of one who sometimes takes on the material accoutrements of capitalist consumerism, being driven around in a Mercedes and advertising their skills through the media and even online, or, as among the Masowe Pentecostal Church apostolics in Zimbabwe described by Engelke (2007; 2010:180-86), wearing cheap white robes to express their rejection of modern materialism. But they often share with non-Christian witchfinder-prophets a reputation for medical treatment, despite ambivalence as to how much their healing powers derive from traditional sources (Engelke 2010:189-90). They are, in other words, part of the regional provision of healing.

## A triangle of healing sources

Let me move for a moment from a concern with patient-healer interaction to the variety of healers themselves. We can make something of an abstraction from the complex reality of numerous, cross-cutting choices and sources of therapy. There is first the sheer difference in operational scale between a) local healers, who mostly treat only neighbours, b) prophetic figures, who treat whole regions and sometimes a nation, and c) biomedicine whose notionally universal clinical approach ranges widely from small rural health centres to urban and peri-urban hospitals and clinics. We can think provisionally of this as being a triangle of indigenous local-level healers, biomedical doctors, nurses, clinics and hospitals, and translocal or regional healer-prophets<sup>4</sup>. The latter may themselves have started as local healers and established broader reputations, but sometimes an individual comes to translocal prominence rapidly through the performance of alleged miracles. Biomedical practitioners may sometimes refer patients to indigenous healers, just as the latter may make referrals to the former and sometimes make use of biomedicines or equipment (e.g. pills, stethoscope, and clothes and premises imitating a biomedical surgery).

The triangle of biomedical practitioner, local healer and healer-prophet-witchfinder is therefore clearly one of admixture informing perceived distinctiveness on

the part of patients and their families as consumers. Each point on the triangle may be at the origin of trust talk in the sense that people communicate with them on the assumption that they are genuinely able and willing to cure. But I surmise that, in the rural areas of Africa to which I refer, a more likely path is for local healers, by virtue of their embeddedness in a local community or, if operating from a distance, their social understanding of local communities, to be at the origin of trust talk, and for either biomedics or healer-prophets as being the next likely therapeutic authorities able to appropriate cases should trust talk break down into alienable talk. In other words, the likely path is from the trust talk of local healers (and sometimes of local biomedics), a loss of such trust, and the appropriation of further talk by socially distant biomedics and regional prophet-healers.

Admittedly this claim has to be modified. Just as trust talk may be initiated at any point on the triangle, it is also clear that there are situations when patients deliberately seek distant and previously unconnected healers/doctors, especially in dealing with sexual and reproductive problems. Perhaps, indeed, this is an increasing feature of modern therapeutic provision. It points to the fact that medical trust talk and its alienation are specific modes of communication, which evolve in particular circumstances and are not always tied to different types of healers. In the rural areas of such societies as Giriama, however, I contend that the triangle has heuristic value in tracing differences of operational scale and a tendency to move from local to non-local sources of treatment, notwithstanding times when people go against such a tendency.

As part of this movement within the triangle, alienable talk may in time be re-established anew as one of interpersonal trust, perhaps following events prompting or requiring co-operation and emotional understanding. There is therefore a possible cycle of trust and alienation in the talk about sickness and misfortune in a relatively stable community. The definition and occurrence of 'stable' and 'community' are clearly problematic and diverse and will be explored later in this paper.

Also problematic are definitions of the three healers making up the triangle. First, when I speak of local-level healer, I have in mind those that I studied among rural-dwelling Giriama in Kenya and those of Zanzibar in Tanzania, Malindi in Kenya and other urban stretches of coastal east Africa (McIntosh 2009; Parkin 1991 and 2007), the former mainly non-Muslim and the latter Muslim (a distinction that may also have profound implications for curative choice). Such local healers include male and female diviners and herbalists with varying degrees of specialisation (Parkin 1991:162-191). McIntosh also draws attention to some of the many specializations by which urban non-Muslim Giriama healers may be classified (2009:281), alongside

those that embrace many such special skills. Second, biomedicine, too, is by no means regarded or practiced as a homogeneous healing system. There is interpersonal and inter-clinic variation in the reputations of biomedical doctors and personnel for treating particular afflictions. Some, though not all, are prepared to refer patients to local indigenous healers. There are also differences in the availability and provision of bio-medicines and equipment at health centres, clinics and hospitals. Finally, as indicated in the literature cited above and more recent findings (e.g. Yamba 1997), there are remarkable similarities between the biographies and practices of the many witchfinder-prophet-healers reported in Africa, but there is also variation in their methods, reputed success, communicative modes, and regional spread.

Despite variation within each of the three healer 'types', my impression is that they constitute a rough triangle of salient sources distinguished as such by people, who are seeking cure and the reversal of misfortune. It does not take account of, for example, the introduction in urban East Africa of traditional Chinese medical doctors, and it will be interesting in due course to see how far these too become regarded as a significant healing source for the majority of the population, so furthering therapeutic diversity (Hsu 2009). For the moment, then, I focus on transformations of trust and alienable talk within a triangle of local, regional and biomedical healers widespread in eastern Africa and probably in other parts of Africa.

## The struggle to retain trust

Trust talk in healing is not everywhere alienated. Institutional checks may prevent this, especially in what were traditionally small hunting and foraging bands with limited or absent formal hierarchy. Moving for a moment away from Africa, we find Sansom (1982) graphically describing how members of an Australian Aboriginal community had developed an understanding that a person's particular sickness could only be talked about by one other designated member of the community. Since every member is sick at some time and more than once, and since everyone will therefore be both care-giver and cared-for within a variety of cross-cutting relationships of trust, the community is knit together by such talk. No one has the right to appropriate from others their talk about other people's particular sicknesses and so no hierarchy of healing talk can arise. Disputes and even fighting result from breaches of this rule that communal trust rests in its observance. What is interesting about Sansom's



description, is that the community as a whole stops short of cooperating in the collective cure of a particular patient, who is suffering of sickness or misfortune. For that we can turn to other cases.

As evident in Victor Turner's and many others' subsequent accounts, much African ethnography refers to people collectively discussing the causes, consequences and cure of a person's sickness or misfortune, regarding it as the concern of the community as a whole in its possibly contagious effects (e.g. Turner 1968:52 *passim*). Sometimes the precipitating sickness event or misfortune is captured early on by established figures of authority who tell those affected what to do. A sequence of turns makes up the trust talk. Among the Giriama of Kenya, diviners or shamans may first be consulted, who then refer the matter to a herbalist, or explain to the afflicted what they should do, sometimes also referring obliquely to local enmity as a contributory but remediable element. Thus, a child may be sick but in due course recovers from the fever and nothing more need be done in this particular instance. But sometimes the child does not recover, or settles into a chronic disability. A biomedical doctor may also be suggested, but this too may not work. Shaman, herbalist and doctor have all failed, as have the neighbour/kin elders who had confidently first directed advice.

The initial turn-taking in trust talk has become a simultaneous outcry. Anxiety turns to fear, which spreads to other members of the homestead and network of relatives and neighbours, who become concerned for their own children's safety. Witchcraft of an especially powerful kind is suspected. Cases of child sickness from around the locality are brought in as allegedly produced by the same malevolent source. Communal discussion turns to panic as a collective witchfinding session is organized, which identifies the alleged culprit who, nowadays, may be fined and forced under oath to cease his/her witchcraft but may in earlier times have been more severely dealt with. The rough reversion to social normality is, I would argue, tainted by hurt suspicions and distrust, and needs a prolonged peace for trust to re-emerge. Trust talk may then re-emerge as an idiom for addressing a new calamity among, say, villagers or kin, perhaps cyclically leading again in due course to fragmentation, panic and resolution through collective action. It is a cyclical process that is made more difficult under modern conditions of warfare and the HIV/AIDS pandemic, with alienation and distrust settling in for a long time (see Yamba 1997:206).

Nor, when there is prolonged alienation among members of a community, is there always a period of trust before panic. Sometimes, the sickness event or misfortune is met immediately by a simultaneity of conflicting interpretations and there is no orderly referral to a succession of experts. Not just one child but a number are sick

within a matter of days. The suddenness of this collective affliction is dramatic. Accusations of different kinds fly about within the group of interactive individuals and families. Some target alleged witches, others suspect violations of ritual prohibitions (e.g. incest or other improper sexuality), and still others the occurrence of ‘unnatural’ or ‘monstrous’ disorder (e.g. allowing life to a breech-born child or one whose bottom teeth grow first). None of these causative wrongs need be in immediate evidence. It is enough to think that they have happened and are for the moment hidden from view. If there are no figures of expert authority, such as shamans, herbalists, and other healers, or respected and recognized sages, it is then more difficult to find a swift resolution to the problem, not just of cure, but of how to address the crisis.

Among the Giriama and among many ethnographically reported peoples of Africa, there is indeed normally some authoritative response to what we may call identifiable afflictions. The same procedure as described above occurs: shamans/diviners, herbalists and biomedical doctors are consulted, not necessarily in this or any other regular order, and, if chronic, the problem is addressed collectively. Malaria, cholera and measles complications, all being frequent causes of childhood sickness and death, tend to have seasonal peak occurrences and so appear to respond positively in due course, at least during periods in the year when conditions allow for some respite. Through the healers, a hierarchy of judgments reinforces the importance of observing proper and customary behavior, guarding against the envy causing witchcraft and temptations of illicit sexuality. Peoples’ talk and their initial raw experience and fear of child loss is thus alienated from them and converted into moral blame and sermon. This kind of alienation of talk is an inevitable feature of a society that depends for its shared morality on senior and expert figures to make sense of and manage the horrors of sickness-related experience and death. State-sponsored institutions and regulated health systems may of course (try to) exercise this role but, in remote rural areas of the kind still found in much of Africa, it is the immediate local hierarchy that is mainly responsible for providing moral explanations and remedy.

This is, however, nowadays only a partial picture. *Prima facie* one might expect that the HIV/AIDS pandemic has lessened the possibility of such response, for the condition’s apparent uncontrollability and rapidity, especially before the introduction of ARV drugs, might be expected to have cut into the localized pattern of indigenous and biomedical expertise. This is not to say that it has not expanded the offer of services by local, regional and national healers. There has in fact been widespread competition among rival healing agents and agencies to promote alleged cures for AIDS, and people travel even more widely than before in search of them. But the

local, relatively integrated provision of healing through shamans/diviners, herbalists and biomedicine is no longer as it was before the pandemic. It is now a matter of time to know whether a wider distribution of ARV drugs and better clinical facilities, including the role of NGOs, will allow local healing provision to become re-established or whether it will now permanently be reorganized and dispersed (Beckmann 2009).

Trust talk about sickness, then, may dissolve into argument and distrust if no agreement is reached on cause and cure and too many interpretations are made of the malady. It may be saved from further degeneration into impotent panic and chaos provided there are persons in recognized positions of healing authority who may then convert the talk and experiences into moral propositions and/or practical solutions. These authority figures certainly alienate that talk and experience but, we might argue, provide restorative explanations which, while they may not always save particular lives, should often enough coincide with normal sickness decline and some restoration to normality.

## Radical change

Although idealized, the distinction between the two types of talk reflects what I understood of the Giriama as a self-consciously holistic society until about the mid or late nineteen eighties. That is to say, I see the Giriama at that time as an ethnic group that placed considerable value on identification with key centres, especially its main 'capital' or Kaya, and indigenous territory and on what they claimed was a single language, kinship and clan system and political separateness. In fact, an outside observer would see them as having been economically more widely dependent, and historically and socio-culturally more complex, than such standardising claims allow. Nevertheless, given the relativity of such claims, the evidence provided by the historians Spear (1978) and Brantley (1981) suggests a long-standing capacity on the part of the Giriama to retain flexible boundaries by retreating into the hinterland when militarily threatened, even while they at other times, such as severe famine, had to compromise with neighbouring peoples in exchange for food. This ability in the past to withdraw and retain some degree of ethnic coherence is re-expressed nowadays in the veneration of the Giriama Kaya as defining Giriama ethnic identity and as providing from its protected, primeval forest the complete range of medicines used by healers (Parkin 1991; McIntosh 2009).

Has, then, the advent of HIV/AIDS altered this notionally integrated view of the provision of healing? Have the Giriama, for example, accommodated the affliction within their local grid of sickness knowledge and practice? Janet McIntosh's meticulous account of Malindi suggests the development of specifically urban modes of sickness treatment involving both Giriama and Muslim Swahili-speakers (2009:127-255), and it is quite possible that their heterogeneity is increasingly characteristic of rural Giriama areas. Recent and current research in such areas by Ishmael Baya and Kaz Keida (2010) may show the extent to which this may now be the case. Alternatively, it may well be that the pandemic has been incorporated within the pre-existing rural set of diagnostic and curative options. If so, this might be explained by the still-continuing sense of coherence of the Giriama as an ethnic group (and perhaps, though to a lesser extent, the Mijikenda generally), who, as mentioned, have for generations maintained a degree of autonomy through 'escape' into the vacant hinterland, while also along the coastal area being subject to territorial, political and economic containment, first by coastal Arabo-Swahili and later by nearby coastal settlement and land acquisition by Kenyan up-country Kikuyu and Luo in particular.

Among the territorially more widespread Luo of Kenya and Tanzania for whom we do have recent and thorough accounts, the pandemic does not appear to have been accommodated within pre-existing modes of sickness response. Geissler and Prince speak of the stigma of HIV/AIDS that delays treatment and sometimes results in the abandonment of customary burials of female victims (2010: 33n11, 200 and 224n3; see also Shipton 1989; 2007; and 2009). Dilger (2010) describes the ambiguity of feeling, which kin and neighbours may have towards victims among the small minority of Tanzanian Luo. Urban migrants returning to a rural home and afflicted with disease and wasting symptoms may be resented for the care that they will now need and stigmatized as having brought it on through their immoral sexual behavior. Yet, at their burial, they may be remembered as virtuous persons who were not to blame for the disease, which was brought on by witchcraft or the violation of a ritual prohibition, summarized as the results of *chira*, a widespread sickness incurred because someone, not necessarily the victim, ignored a rule of seniority or committed a form of incest, incestuous adultery or unacceptable sexual behaviour. This temporary rehabilitation of character is said to quell the possibility of the dead person vengefully returning as a ghost to trouble the living. In other East African societies, too, affection may be expressed for victims at their burials, as Whyte shows for Banyole (2005:163 and *passim*), though for women in particular it is also often difficult for AIDS victims to be found a willing 'home' in which to be buried. Among such societies, sympathetic

burials may therefore be only a humanely quiescent interlude in what has otherwise become an “increased delocalization and weakening of kinship bonds resulting not only from rural-urban migration and the strains of economic hardship but also from the growing HIV/AIDS epidemic (which among Luo) has led to the discourse on *chira* gaining in popularity” (Dilger 2008:220 (my bracketed inclusion); Geissler and Prince 2010:89-92).

Dilger describes responses to the plight of AIDS victims and how different healers and biomedical sources are consulted, but with conflicting and unsatisfactory interpretations and diagnoses. He cites the comments of individual Luo who have to witness the tragedy of uncontrollable death, who speak desperately of the threat of extinction confronting the people, and who proffer violently conflicting reasons for the deaths. The impression is of an absence of trust talk, which is only for a little while regained at the victim’s burial. The talk is thus alienated from them by religious and political leaders who, while they earlier pronounced the disease as divine punishment for peoples’ ‘immorality’ (2008:209), now refrain from such stigmatization and talk in a neutral’ language, along with other organizations (ibid: 228). While this move towards talk, which de-stigmatizes the disease, is understandably intended to reinforce health campaigns aimed at practical measures of prevention, it curiously fails to address the emotional loss and bitterness that victims and their families continue to experience. What has happened here is that these wider religious, political, organizational and health authorities have taken on the restorative role previously occupied by local-level healers, who would appropriate peoples’ anxieties and convert them into customary explanation. The possibility of trust talk becoming reinstated in local communities is decreased since the terms of sickness understanding are increasingly in the province of the wider authorities, this being an ineluctable tendency in government and religious public health attempts to address severe epidemics. In other words, it is possible that among the Luo described by Dilger (2008) and by Geissler and Prince (2010), and among other peoples under comparable conditions, talk about sickness and misfortune begins on these alienated assumptions, with less likelihood of talk based initially on common trust, even among people in regular interaction with each other, as described in various ethnographic accounts of the effects of HIV/AIDS.

Yamba (1997) provides another case where people’s sense of distrust is paramount. He appeals to the long-established finding of Evans-Pritchard that witchcraft explains why a sickness or misfortune afflicts a particular person or group, and not another living in similar circumstances, and that this fills the gap left unanswered by bio-

medicine and so-called rational positivism, whose appeal to ‘accident’ as giving rise to the malady, in fact side-steps causative explanation. Yamba’s vivid depiction of the rise to influence of the Zambian witchfinder, Chaka, shows the complementary powerlessness of local authority figures who can evidently do nothing to halt AIDS deaths, whereas Chaka successfully kills off those proven by him to be the culpable witches and so sets up and pursues the promise of a ‘cured’ future without them and their heinous evil effects. Yet, it is these same local figures or officials who eventually regain local authority in association with Chaka rather than at his expense, doing so through the rhetoric of biomedical cause and effect at an opportune moment in the crisis. The drama shows clearly how the attempt at so-called rational argument by the local establishment to portray AIDS as caused by sexual contact and therefore as eliminable through sexual controls, is at first undermined by the mob who bay for the death of the alleged witch among them, before the pendulum swings away from the power of the mob and back to local authority. In their baying, the members of the mob are themselves divided as to who is responsible and even on how the witchcraft should be dealt with. It is a clear case of panic expressed in talk which is in due course alienated from them by local authorities who revert to standard appeals.

As indicated by Yamba and others who have investigated the ‘modernity’ of the resurgence of witchcraft in Africa (Geschiere 1997; Comaroff and Comaroff 1993), local peoples and elites alike regard their life courses as having lost the predictability and orderliness they may once have had, a relativistic claim which may still carry some truth under exceptional modern conditions. If we were to impose a western epithet, it is that they are suffering irrational life-courses, where plans for a child’s school future, one’s family and career, and for building material and spiritual capital, are constantly reversed by events and persons beyond one’s control, even when the prescribed and supposedly correct courses of action have been taken, and where the apparently deserving fall back and the allegedly undeserving triumph. While many locals are aware that external and ultimately international factors (e.g. structural adjustment, fluctuating commodity demand) constrain their crop yields and prices, and their educational and socio-economic opportunities, in the way described by the above scholars, this awareness is rarely enough to explain the uneven and apparent arbitrary nature of affliction. Those who see themselves as playing by the rules should prosper and be healthy, but this is not always so, while those regarded as flouting the rules may stay well and thrive. Confidence that the future should bring the just desserts of one’s hard efforts is instead reduced to chronic uncertainties.

It is in this situation that the play of trust talk and panic-driven alienable talk is so volatile. As Yamba's case illustrates, panic talk, whether of the mob or of co-arguing individuals, seeks solutions from whatever direction they may be offered. The witchfinder resolves the inconsistencies of the panic talk by offering a final solution in the form of a poison oath, which condemns those accused who are afraid to take it, and kills those who do. It is a combination of chance and the existence of a state-backed higher local authority possessing the biomedical rhetoric of disease causation that stops the witchfinder from assuming even more power and killing even more alleged witches (though Yamba suggests his tally was nonetheless very high in any event). Witchfinders do not go on indefinitely. Popular disillusionment in their abilities and government pressure, sometimes reversing earlier official permission, curb their activities, but in due course another witchfinder arises and the cycle is repeated.

### On the place of confidence in uncertain life-courses

Moderating the view described in the previous section, of the decline in local trust that allows witchfinders to flourish, is that which points to the increasing number of cases in which members of communities confront the prevalence of epidemics, often doing so in the face of opposition and sometimes themselves suffering from the contagious affliction that they combat on behalf of their community. There is now a considerable literature on the development and role of informal carers, especially in relation to HIV/AIDS. Obbo has discussed, for instance, the growing role in southern Uganda of women as carers for victims in their own and other families (Obbo 1998), as has Thomas for Namibia (Thomas 2006). Beckmann (2009) has shown in detail how key individuals in Zanzibar must first overcome Islamic theological resistance as well as that of neighbours and kin in order to lessen the public stigma of infection and bring people to allow themselves to be treated by the new ARV drugs. The starting-point for such carers has to be that of persuasion and the assumption that they can re-grow the trust necessary for discussion to proceed to mutually agreed ways of coping with the epidemic. That is to say, they have to cut into the negative and often contradictory talk about the stigma and causes of an epidemic and convert it into acceptable judgment and procedure. Of course, enlightened NGOs and sometimes government health units also do this. But it is the local level contribution, which is vital for the trust talk to be resumed as a customary response to sickness and

misfortune, and so some kind of personal link has to be made with members of the community who can act as enlightened carers and proselytizers.

Local carers are often themselves sufferers and so are in a sense an intermediary instance between established healers and their patients: they themselves require attention as does a patient and yet they provide help to others who are afflicted. In other cases, carers, as in the case described by Obbo, are the as-yet-uninfected remaining members of diminishing kin and neighbourhood groupings, who see their own humanity as mortally vulnerable and so precariously merged with that of the dead and currently suffering. Carers create the conditions of possible trust, against all the odds, even if, in the absence of alternative plausible explanations, they must explain the sickness and death as little more than 'God's will', often in the face of counter-accusations that it is all caused by the witchcraft of others' envy (Yamba 1997). They create the bedrock on which new trust talk can re-grow if and when the plague retreats. They are poised between the alienable panic talk characteristic of stigma and the trust talk that they wish to create by dissolving stigma.

Significant here too is the situation outlined by Whyte, where affection is interwoven with appeal to 'cultural' rules of legitimacy, and where trust talk can supersede panic talk. Indeed, trust talk is here more than just an appeal to rules. It is also founded in local affection, which, if sufficiently held in place, withstands its alienation by higher authority. Whyte describes how 'men were more likely than women to justify a course of action by reference to "Nyole cultural rules" and yet "also mobilized arguments of affection at times. Elements of both calculation and compassion can be found in men's accounts of the circumstances under which their (perhaps) married daughters died and were buried"' (Whyte 2005:157-158). This observation points to what I believe is the underlying existential frame within which trust and alienable talk alternate. The experience of suffering may evoke sympathy as well as blame. That is to say, it elicits trust in the essential virtue of the sufferer, who is after all a member of the local community, as well as commentary and condemnation of the violation of cultural rules resulting from his/her or another's illicit action, usually with regard to incest, improper sexuality and failed obligations of kinship and affinity.

There is the implication in Whyte's remark that here men turn more towards a kind of cultural explanation of affliction than women, while both will also express compassion in the face of this culturally rational discourse. Given the largely male-dominated domestic authority structure, there is nothing surprising about this use of custom to support it.



Extending beyond domestic relations, however, are those of the local medical establishment, ranging from traditional healers to biomedical practitioners and NGOs. It is clear from innumerable accounts of shamanism, divination and herbalism in Africa that traditional healers already interweave issues of local compassion and trust with those of the dangers and condemnation of cultural rule violation. Thus, classically, the victim may have incurred someone else's jealous witchcraft through their own thoughtless disregard of that person's feelings (displaying new-found prosperity in the sight of an impoverished kinsman or neighbour), entering the passionate embrace of a brother's wife or classificatory sister without at the time contemplating the possible consequences, or otherwise ignoring a ritual or behavioural expectation. In addition to asking questions concerning the particular physical or social ailment, traditional healers probe clients for general personal and social information because these are deemed to be equally, if not more likely, to cause the chronic nature of the patient's complaint.

What is noteworthy is the presumption on the part of the healer that the blame for the affliction is already a shared endeavour (the victim of witchcraft incurring it through thoughtlessness and the witch giving way to his/her jealousy or envy). The healer starts with the notion of collectively shared cause and complements this with a holistic investigation of the whole person and his/her community. Ideally it is then up to the community to talk out the shared problem. Holistic diagnosis and cure should cohere. In practice, collective trust talk in, say, a homestead or village is not necessarily always commensurate with the activities of traditional healers, as is clear from Yamba's Zambian case. But it is the ground on which it is made possible, provided healers remain tied to localities and stand in set and proportionate relationships with each other, and with competition among them not being an explicit feature of their practice.

Thus, among Giriama, there was a convention that only a limited number of healers operated in relation to a recognized community and that their diverse specializations were not too close to each other (Parkin 1991:164-165). Feierman (1990:6) also talks of similar constraints on competition among Shambaa in Tanzania, where contesting rainmakers who pit 'power against power' harm the land and its people, but where suppression of such competition 'heals the land'. This regard for the local and craft autonomy of individual healers not only reduces competition between them, it facilitates clear lines of trusting communication between each healer and his/her local constituency. Only healers of increasingly outstanding reputations for success would come to be regarded as acting above local sections and for the 'nation' as a

whole, sometimes relocating to a base away from their home area. The convention of locally proportionate professional service to communities appears to have collapsed among the Goba of Chiawa in Zambia and the Luo of eastern Africa, according to Yamba and Dilger's accounts, as relationships between healers turn to commercially explicit, competing rivalries. What is also important is that the earlier convention, in making trust talk possible, is also the potential link between traditional healer and biomedical practitioner and medical NGO. This is because trust can be funneled up from healer to these externally introduced medical institutions, rather than the talk being alienated from the victims of suffering and converted into the language of hierarchised judgment and new behavioural prescription, possibly punitive and dissociated from previous customary understanding.

Now it is evident that these grounds for the retention or revival of trust talk in order to solve problems of affliction presuppose relationally balanced conditions of communal living, kinship and affinity, few of which can reasonably be said to exist under modern conditions of population expansion and dispersal, land scarcity, urban economic or rural cash crop dependency, and diminishing access to health and educational resources. But the notion of community remains a viable one provided these other conditions are radically altered, an issue which affects not just Africa but much of the world as a whole. It is true that the turn in the social sciences to globalised networks, diasporas and transnational communities does characterize an analyzable dimension of modern and late-modern human existence, and that earlier concentrations on relatively harmonious rural, kinship-based communities reflected an idealism more than the harsher reality of communal conflict. But the notion of local community as a partially self-regulating entity still deserves consideration, both as a social fact in some rare past and present instances as a social possibility. In another era, it might have been said that excessive healer competition and de-localisation requires a return to the idea of planning for communities of a particular form, size and disposition. The resistance to such suggestions is of course likely to be massive when promoted as part of an overarching state political ideology, and not without reason in many cases.

Yet, in a curious way, the spread of world religious organizations throughout Africa and other parts of the world is in fact producing unplanned and relational if competing configurations of communities, such as the invented "village Christianities" discussed by Ranger (1993:66). For, while Christian churches and hospitals compete against Muslim mosques and clinics, or while Pentecostals and Catholics, or Shia and Sunni also compete internally against each other, they also each become

the foci of often fervent groups of belonging, sometimes reproducing lineage, clan or village contours or ‘providing an alternative community to that of kin’ (Geissler and Prince 2010:82), and sometimes allowing membership drift from one relatively enduring organization to another (*ibid*:66). The place of traditional healers in such religious organizations is always problematic, for they may seem to hinder ‘the break with the past’ which, for example, Pentecostals often advocate (see Engelke 2010:181 discussing *inter alia* Meyer 1998 and others). Such healers are not normally accepted within the churches but, to a remarkable extent, practice alongside them, or their skills and powers may be grafted onto the community leaders or prophets of the religious organization.

This feature of the global within the local and of traditional healing within church or mosque, is a medical as well as religious encompassment. The traditional healer draws on animistic beliefs, while the Christian and Muslim missions normally propagate bodily as well as spiritual welfare, bringing in clinics, hospitals and biomedical doctors. It is an accommodation of institutions that has the potential for restoring or inventing communities and therefore the possibility of setting up the conditions of trust talk among its members. But such a development would require the medical and religious establishment to accept traditional healers as being part of their constituency, to allow for communicative, collaborative and referential links between healers and doctors, to accept mutual debate of their respective epistemologies and epidemiologies, and to acknowledge the implications of the fact that unequal distributions of power and alleged expertise lead to the alienation of trust talk and its conversion into moral judgment and rule-based prescription. Morally prescriptive admonition may of course produce healthcare benefits: use of condoms, safe sex and abstinence, and perhaps checking and redefining post-burial sexual consummation of widows by marriage heirs, might well reduce HIV/AIDS infection. But these putative benefits may also bear costs (and perhaps be rejected as such) if taken to moralistic extremes that significantly impair peoples’ life-styles and preferences. How to secure a mutually acceptable balance is only possible through the development of trust talk, not just among locals however, but between locals, including healers, and extra-local medical authorities and NGOs, including those accessible through organized religion. This in turn means recognizing the conditions under which talk becomes alienated from communities.

In other words, as Kleinman so eloquently argued for biomedical practitioner-patient relationships, a considerable amount of time and focus deployed by the doctor in understanding the fears, emotional sense of loss and sense of explanatory

betrayal experienced by patients, does create mutual trust, with often remarkable results for the chronic illness of the patient (Kleinman 1988:137-157). Focusing only on the supposed physical causes and course of disease loses that possibility of trust and easily becomes the basis of moral prescription. A problem with many establishment religious organizations, as with some biomedical institutions and practitioners, is that they seek dialogue that puts moral judgment and practice in place of informed consent and discussion of future options. This appropriates talk before it has even begun to take the form of reciprocal dialogue. The implication is paradoxical for those who wish to convert local communities to biomedical understanding and practice and/or to a religious persuasion. This is that the more that time is given over to trust talk in local communities, with proportionately less devoted to actual biomedical or religious content, the greater the chances of conversion.

## Conclusion

Analytically we see how the power element in healer-patient relationships may, within a wider scale of healing possibilities, become also a question of retaining trust talk in the face of its alienation by higher medical authority. Treatment may pass from local to regional healer, and/or to biomedical practitioner, who, in eastern Africa, constitute an inter-relational triangle of perceived healing possibilities. Outside Africa and more generally, there is the suggestion in other accounts of a similar transformation of talk or report along the trust-alienation spectrum within biomedicine itself, especially with regard to the interplay of emotional, moral, and clinical discourse. Recent work tends to follow Atkinson's emphasis (1995) on talk among biomedical specialists rather than between them and patients, and on the subsequent production and transmission of medical knowledge. Such talk is not therefore of the more generalised kind that figures in a face-to-face rural, moral community as described in the current paper, but is surely to be treated as part of a wider complex of therapeutic talk in which different rhetorics of explanation, judgement, appeal, trust and loss of trust jostle among healers, patients and participants.

Brodwin (2008) describes how the uncertainties of clinical talk in US outpatient psychiatric units are taken up by the formal and abstract ethical precepts of front-line clinicians and become part of a resultant everyday moral talk. Waring (2009) shows how among staff of a UK teaching hospital emotionally laden medical narratives on

risk management and patient safety are ‘reproduced as incident reports which transform knowledge through check-boxes and pre-defined categorisations’ into ‘narrow narratives’ and thence into authorless managerial assumptions. Iedema and others (2009) provide an account of how conventional ‘linear’ talk among hospital students gives way to doubts and horror as they reflect on possible mistakes and inadequate patient safety precautions, and in so doing challenge the non-emotional linear narrativity of established medical discourse. These accounts do not specify when the talk is premised on trust or on the loss of trust but, it seems to me, such alternating elements are implicit in the reports and verbal exchanges. I would conclude by saying that, whether we confine ourselves to biomedicine or depict a plurality of types and scales of healer or of medical traditions, this dynamic alternation of forms of talk is intrinsic to therapeutic discourse, for it plays on the possibility that the personalized trust, that is sought by afflicted people, becomes lost or alienated to increasingly depersonalized pronouncements.

## Notes

\* Thanks are due to the two anonymous reviewers for their helpful comments and suggestions.

1 Vertovec’s suggestion is that ‘super-diversity’ includes changes to pre-existing socio-cultural diversification mainly brought about by new kinds of international immigration layered upon earlier waves of immigrants, especially as a result of momentous events such as the fall of the Berlin wall in 1989, the radical reforms in China from the 1990s, and the ending of apartheid in South Africa. Smaller groups of new kinds of immigrants have thus been added to more settled groups originally of immigrant status. Such developments have had a global ripple effect in migratory movements even in areas not experiencing directly these particular changes, such as eastern Africa whose population has a markedly higher proportion of migrants from other areas of Africa and, especially, has seen the influx of Chinese and other Asian entrepreneurs and traditional Chinese doctors.

By this token medical diversity, or medical super-diversity, refers to more than medical pluralism, if by the latter we mean a number of medical traditions co-existing in a region relatively insulated from each other. Diversification implies mutual borrowing of ideas, practices and styles between them, and by implication more differentiated strategies adopted by patients in search of cure. This is the sense used in the current paper. One anonymous reviewer added the reminder that medical diversity in the biomedical field refers to ethnically diverse biomedical staff or bodies, the latter regarded as genetically different and therefore needing different treatments, and the former as providing within an ethnically diverse group of practitioners the availability and opportunity to manage different competences.

- 2 On the East African coast in a town like Mombasa, an authority comparable to the rural biomedical practitioner is a Muslim healer who uses a combination of biomedical and textually based Yunani treatments and also operates from a clinic.
- 3 Personal communication.
- 4 As indicated above, there are some Muslim Yunani healers who operate in coastal towns in eastern Africa and whose use of biomedical materials and styles alongside Yunani and Islamic techniques and texts makes the more or less equivalent to biomedical practitioners. I do not include them here since their clientele tend themselves to be coastal urban Muslims.

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