Local interpretations on malaria and the discourse on the traditional health care providers in southern Mozambique[1]

Interpretações locais sobre a malária e o discurso sobre os provedores tradicionais de cuidados de saúde no sul de Moçambique

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Abstract

The narratives on the diagnosis and causes of malaria are diverse and apparently ambiguous, being based beyond the body, on the social relations among peers, their ancestors, and nature. Based on a qualitative study and a four-year stay in Mozambique, this article analyzes the discourses of patients and biomedical practitioners on traditional health care providers, i.e., tinyanga and zion pastors, linking them to local terminology of malaria, in a rural district in southern Mozambique. In the current context of therapeutic pluralism and high mobility, the lack of solidarity and compassion attributed to tinyanga is supported by the monetization and commodification of their medicinal rituals and knowledge, as well as by competition with other providers in attracting patients. The implementation of zion churches, of Christian nature and performing therapeutic practices similar to tinyanga, is presented as a local advantageous solution due to the strong community connection, the comfort and reciprocity among the members, and the therapeutic results at low cost. In terms of health care policies and clinical practice, the invisibility of zion pastors and the subordinate role of healers is managed according to interests, based on vague ideas and prejudices from biomedical providers. The implementation of health policies that address the local diversity, the existing power relations and medical knowledge and practices can strengthen the biomedical care services and harmonize relations between the providers and the population.

Keywords: Malaria; Mozambique; Traditional Healers/Tinyanga; Zion Pastors; Local Illness Interpretation.

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Resumo

As narrativas sobre o diagnóstico e as causas da malária são diversas e aparentemente ambíguas, sendo baseadas para além do corpo, nas relações sociais estabelecidas entre pares, os seus antepassados e a natureza. Com base num estudo qualitativo e na permanência em Moçambique durante quatro anos, este artigo pretende analisar os discursos dos pacientes e praticantes biomédicos sobre os provedores de cuidados de saúde tradicionais, isto é, *tinyanga* e pastores ziones, articulando-os com as terminologias locais da malária, num distrito rural no sul de Moçambique. No atual contexto de pluralismo terapêutico e elevada mobilidade, a falta de compaixão e solidariedade atribuída aos *tinyanga* é fundamentada pela monetarização e comoditização dos seus saberes e rituais medicinais, bem como pela competição com outros provedores na captação de doentes. A implantação das igrejas ziones, de cariz cristão e com práticas terapêuticas semelhantes às dos *tinyanga*, apresenta-se como uma solução local vantajosa devido à forte ligação comunitária, ao consolo e reciprocidade entre os seus membros e aos resultados terapêuticos a baixo custo. No nível das políticas de saúde e da prática clínica, a invisibilidade dos pastores ziones e o papel subalterno dos *tinyanga* é gerido à medida dos interesses, das ideias vagas e dos preconceitos que os provedores biomédicos possuem sobre esses provedores terapêuticos. A implementação de políticas de saúde que atendam à diversidade local, às relações de poder existentes e aos conhecimentos e práticas médicas podem fortalecer os cuidados biomédicos prestados e harmonizar as relações entre os provedores e a população.

Palavras-chave: Malária; Moçambique; Curandeiros/*Tinyanga*; Pastores Ziones; Interpretações Locais da Doença.

Introduction

Diverse ethnomedical systems can be identified in Mozambique, with variations throughout the country and depending on the location in relation to urban and rural areas. In the Chókwè society, in southern Mozambique, we identified three groups of health care providers to whom the population resorts when facing a case of malaria or another disease. The subjectivity of the health care providers emerges not only in the performance of their medical and therapeutic expertise, but is also the product of a certain socialization, of the repository of their experiences, expectations, motivations, and prejudices. The medical knowledge and practices are permeable to context and to different experiences of caregivers and, in decision-making, all these factors must be considered. Reports relating to health care providers, in the district of Chókwè, are characterized by a great diversity of experiences that value the care, sensitivity, and respect for the patient's condition, which must underlie all therapeutic practices.

Diseases, and malaria in particular, are a complex phenomenon, given the diversity of health care providers, their functions and discourses throughout history, the multiple actors and economic, environmental, social, and political factors determining the experience of disease.

All knowledge on health and disease, arising from health care providers and patients, is the "product of a natural, social, and cognitive process, rather than of a logical process" (Santinho, 2011, p. 87), built and accumulated, with roots in the past and founded on the relational and subjective experience of the social groups and institutions that reconfigure its body with significations and practices concerning disease diagnosis, management, and treatment.

This article aims to present and analyze the discourses of patients and biomedical practitioners on these health care providers, healers/*tinyanga*[2] and

2 The term healer is used here as a synonym for traditional medical practitioner and nyanga (sing. and tinyanga (pl.) in xiChangana). However, throughout this article we give preference to the expression in the local language (nyanga). The term "healer" was introduced during the period of colonial occupation and continues to be used to this day. In the official discourse, the terminology used is "traditional medical practitioner" (AMETRAMO - Association of the Traditional Medical Practitioners of Mozambique) and traditional medicine, with a limited use by the population.

zaion pastors, who resort to elements of tradition[3], articulating them with the local terminology of malaria, in a rural district in southern Mozambique.

This article is part of a broader study on the relation between patients and health care providers in the context of malaria control activities and is based on fieldwork conducted in southern Mozambique, especially in the District of Chókwè, for four years.

The article is structured as follows: methodology is the next section and, subsequently, the local terminologies and interpretations of the malaria disease will be presented. Following, the analysis of discourses on the *tinyanga* and zion pastors, and, then, the discussion. Finally, the conclusion will be presented.

Methodology

The District of Chókwè, located in the province of Gaza, in southern Mozambique, was selected based on three criteria that interrelate: the high number of cases of malaria (see Table 1); the existence of various control interventions against this disease, implemented by the National Malaria Control Program (PNCM) of the Ministry of health (MISAU), or by Non-Governmental Organizations[4]; and, finally, a prior knowledge of the district by the researcher, facilitating some logistical issues, including accommodation, local contacts, and hiring of an interpreter.

Chart 1 – Number of cases of malaria in the District of Chókwè in 2006 and 2007

Districts	2006	2007
Xai-Xai	217,803	270,823
Chókwè	166,158	108,401
Manjacaze	130,131	88,942
Chibuto	99,762	74,582
Bilene	88,216	71,732
Guijá	48,172	25,875

continue...

Chart 1 – Continuation

Districts	2006	2007
Chicualacuala	18,795	10,846
Massingir	17,160	9,730
Mabalane	15,918	10,506
Massangena	9,294	7,006
Chigubo	8,197	7,835

Source: Courtesy from PNCM – Gaza Provincial Directorate (DPS)

The District of Chókwè has 192,556 inhabitants (Mozambique, 2012, p. 67), having agriculture and farming as its main socioeconomic activities, predominantly in a family scale but also in the agroindustrial dimension, within the irrigated perimeter that covers an area of 30,000 ha (of the total usable agricultural area of 87,178 ha) (Chókwè, 2012, p. 1).

This investigation fulfilled every ethical considerations, having been authorized by the National Commission of Bioethics for Health (IRB00002657), an integral body of the Ministry of Health (MISAU), and at the local level it was supported by the Provincial Directorate of Health and by the District Services of Health, Women and Social Action of the District of Chókwè. Research objectives and methods for record of collected data (audio or written material) were explained to all respondents, as well as the guarantee of anonymity and confidentiality of their reports, with their agreement expressed through the signing of the Informed Consent.

To obtain the authorizations for the conduct of this investigation on district level, local authorities were contacted "in cascade": firstly, the Chókwè District Administration; then, the heads of the four administrative posts (Lionde, Macarretane, Xilembene and the City of Chókwè) and, consequently, the heads of the localities (Macarretane, Matuba, Maxinho, Xilembene Sede, Chiduacine, Lionde,

3 This research considers the tinyanga as the only "traditional" providers of health care. The classification term for "tradition" will be presented in quotation marks, since it is based on narratives of people interviewed and contacted. The temporal and symbolic delimitation between the categories "tradition" and "modernity" is built on the basis of the experiences and memories, at the same time that is articulated with the political and ideological discourse of the time. Thus, the category "tradition" refers my interlocutors to the local cosmology based on nature, on ancestry and society, in a pre-colonial historical moment. About the categories "tradition" and "modernity", see Passador (2011) and Honwana (2004).

4 In 2008, Chókwè was one of the districts with the largest number of International Non-Governmental Organizations (INGO) (12) operating in the health sector in the Gaza Province.

Conhane, Malau and City of Chókwè); and, finally, community leaders for all the villages visited[5]. Within the administrative boundaries of the City of Chókwè, the Municipality of Chókwè was contacted, which organized a session of presentation to all the heads of the districts. Subsequently, the contacts were limited, exclusively, to the heads of selected districts.

The villages visited were chosen randomly, following the criterion of covering an equal number, where existed or not a health center. In the city of Chókwè, the districts were selected according to the criterion mentioned above, and also considering the existence of districts with predominantly rural characteristics, as well as more urbanized districts. The decision to carry out the investigation in several villages in the District of Chókwè, as well as in multiple therapeutic contexts, was pondered in analytical, logistical terms and financial possibility to conduct the investigation, hypothetically enabling the access to a greater diversity of discourses and practices on health and disease.

This investigation was based on a non-probabilistic sampling, often using an intentional selection. In the case of the *tinyanga* and religious pastors, snowball selection between peers was used and with the support of local leaders. In short, 44 *tinyanga* and 41 pastors of Christian churches and leaders of the Muslim religion were interviewed, intentionally and by snowball.

The third group of health care providers interviewed was that of biomedical technicians and professionals, in a total of 19, who were intentionally selected to cover all hospitals and health centers in the District of Chókwè. In the case of hospitals or health centers where more than one technician worked, the interview was usually performed with the person in charge of the health unit and with the person in charge of any of the services.

In addition to the health care providers contacted, interviews were conducted with 87 men and women[6], who were selected intentionally as we walked through the villages and conducted the other interviews with health care providers. Finally, it was also decided to conduct fourteen focus groups with women[7], involving a total of 74. For reasons of fieldwork logistics and cooperation of community leaders, their selection was their own responsibility.

With the exception of interviews with health professionals, which were conducted in Portuguese, most of the remaining interviews were conducted in the local language (*xiChangana*), with the presence of one interpreter/field assistant who performed simultaneous translation. Her presence was decisive in the contact with the population, in participant observation and in transcription of the data collected. Despite several strategies to minimize the effects and risks of the use of interpreters, it is acknowledged that this is a limitation of the study itself (Temple; Young, 2004, p. 164-165).

The preferred mode to register the interviews, focus groups, and other events was the recording of digital audio and the shooting of video (for events). However, there were interlocutors who did not accept the digital recording and, in these cases, notes were taken. In short, of the 205 interviews and focus groups conducted, 138 have an audio record and the remaining 59 have only written reproduction. The interviews in *xiChangana* were integrally translated and transcribed for the Portuguese language (with some syntax-level adaptation), having been reviewed by the field assistant and by the researcher.

To understand the interinstitutional relations involved in the decision-making about the adoption of strategies to control malaria, there were, in addition, interviews in a "central level" in international and national non-governmental organizations, United Nations agencies, multilateral agencies and

5 Maloluane, Manjangue, Matuba, Cumba, Maxinho, Machua, Conhane, Chiaquelane, Mapapa, Nwachicoluane, Massavasse, Kotsuane, Lionde, Bombofo, Changulene, Tlhawene, Xilembene, Hókwè, Muianga, Macunene, Chalocuane, Chiguidela, Zuza, and Municipality (1st, 2nd, 3rd, 4th, and 5th Districts).

6 The age groups of this group are very varied: the youngest respondent was 18 years old and the oldest, 82 years old. Thirty respondents were aged from 18 to 39 years; 22 respondents, from 40 to 59 years; 23 respondents, from 60 to 82 years; 12 did not know their year of birth.

7 The selection of women for the focus groups was due to their central role as caregivers and providers of first health care to children and other members of households. In the context of the understanding of the knowledge and practices associated with malaria, their contribution was essential.

movements of religious nature, all having as a common denominator the support to the PNCM (National Program for Malaria Control) through technical consultants for the implementation and funding of malaria control activities in Mozambique. The PNCM directorate and the Institute of Traditional Medicine (which is part of the Ministry of Health) were also included in this support.

Participant observation was transversal for the period of stay in Mozambique (from March 2008 to July 2012), with special emphasis on the last two years, when there was a daily experience of greater proximity to the *tinyanga*, pastors of Christian churches and of the Muslim religion and community leaders.

Local terminologies and interpretations of the malaria disease

In the society of Chókwè, while belonging to the ethnolinguistic group *xiChangana* and sharing specific social, cultural, and historical relations, access to the diseases' significations, symptoms, and terminology belongs to the private sphere, while they are part of the matrix shared by the members of a society. In parallel, the sharing of linguistic symbols hardly leads us to the sharing of their significations. Using ethnomethodology and the legacy of Coulon, the indexicability in the relation between individuals highlights the contextual determinants that are, implicitly, attached to the word and that go beyond the context in which it is used (Coulon, 1995, p. 17). Within a context of health and disease, access to the significance of the terms is hampered by the suffering and distress of the moment or by the marks and traumas left by a past episode.

On the other hand, Price (1987, p. 313 *apud* Kamat, 2013, p. 82) calls our attention to the information that is integrated as an experience by a third party when saying that: "Individuals gain information about entire illness episodes without having personally experienced those events. Such second hand episodes are integrated with those the person has directly experienced and become part of his or her current script concerning illness". This knowledge, which is socially generated and reconfigured throughout the experiences experienced by patients and family members, reinforces the constant (re)construction and dynamics of traditional medical knowledge.

The different terminologies and the description of the symptoms and signs reinforce the complexity of the analysis of the phenomena of health and disease, as well as the public health interventions promoted by biomedical institutions. The term *malaria*[8] is quite recent in the lexicon of the population of the District of Chókwè, with the exception of those who had a close relationship with the Portuguese settlers during the colonial occupation or had a closer contact with biomedical institutions in the post-independence period, as the military, civil servants, the Mozambican Red Cross volunteers, among other people from the villages with greater connection to the district administration. According to my interviewees, the popularization of the term malaria occurred with the floods of February 2000, when the most affected areas of the Gaza Province received, during several months, workers from various humanitarian NGOs. These organizations distributed thousands of mosquito nets and food aid and conducted health education initiatives in the relocation fields, in which they would explain the importance of personal and collective hygiene, sanitation of environment, vaccination of children and regular use of the mosquito net. Most interviewees mentioned the floods of 2000 as a time of transition, with the emergence of several epidemics never before experienced – referring to malaria, cholera, and HIV/AIDS –, as well as changes in the "way of living", the result of a new occupation of the urban space and fixing of the population forced to move from low areas (along the Limpopo River) and areas next to irrigated crops.

As in studies in southern Africa (Erhun; Agbani; Adesanya, 2005, p. 26; Pool et al., 2006, p. 1672; Hlongwana et al., 2009, p. 7), in the District of Chókwè,

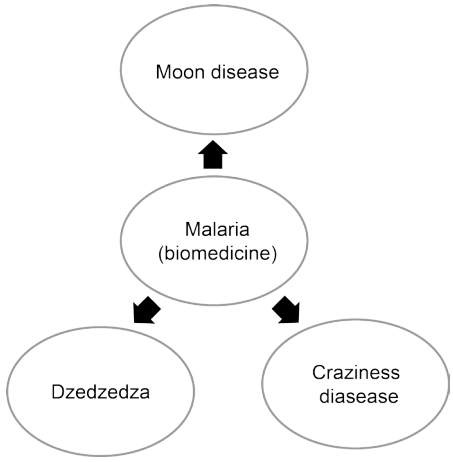
8 Due to the subjectivity involved in the interpretation of the concepts of health and disease, in this article we considered the existence of *malaria* and of malaria, the latter referring to the biomedical category and the first to the enunciation of the interlocutors.

malaria is, in general terms, considered a "disease of the hospital"[9], and patients and family members seek treatment at Health Centers, relying and recognizing in biomedicine the means and knowledge necessary to guarantee a cure. The recognition of "diseases of the hospital" is affirmed as the result of a progressive and adapted appropriation of new knowledge and practices in the area of health. However, as will be shown, the signs and symptoms of malaria may be mistaken for diseases outside the biomedical sphere.

When the interlocutors were questioned about the existence or not of malaria "at that time"[10], the answers were divided between those who considered that, in the past, there was no *malaria* and those who reported that *dzedzedza*[11]– local terminology – has always existed. This traditional designation had been subsequently replaced by *malaria*, thus occurring an amendment of the terms[12]. In the literature available, no explanation was found for these two ways of naming the disease, but it is considered, in this study, that the existence of fever in both diseases (malaria and *dzedzedza*), a high exposure to biomedical terminologies after the floods of 2000, and the diagnosis of clinical malaria whenever the patient had fever reinforce the merging of the two concepts by considering them synonyms.

According to the reports of the interlocutors, if the association between malaria and *dzedzedza* does not generate false interpretations and "mistranslations" between providers and patients, the extrapolation of malaria to other diseases, considered "of the tradition"[13], generates uncertainty in the determination of etiology due to episodes of seizures and, consequently, the uncertainty in relation to the provider to be sought.

Figure 1 – Integration of malaria in the local ethnomedicines and their terminologies



9 Currently, the "diseases of the hospital" are characterized by being those diseases in whose cases the interlocutors recognized the therapeutic power of biomedicine and whose etiology may be linked to the failure to implement preventive measures of collective and individual health, widely divulged in health promotion campaigns and activities, such as no use of mosquito nets, no cleaning of the space surrounding the household, a poor personal hygiene, and consumption of inadequate water.

10 Term used to refer to a remote past, pre-colonial and colonial. Passador (2011) also presents this expression in the building of otherness with a social time and space "fraught with things of tradition" (p. 43-47).

11 *Dzedzedza* refers to fever, feeling of heat in the body. In *xiChangana*, this term is considered an onomatopoeia associated with tremors of cold during the fever.

12 See also Pool et al. (2006, p. 1672).

13 In this investigation, the "disease of the tradition" refers us to a sense of social illness, in which individuals do not see their personal and social aspirations satisfied and, additionally, break or have no respect for social rules defined with each other or with their ancestors. Although the phenomenon of illness is of difficult conceptual delimitation, the "disease of tradition" can be associated with the inability to generate offspring and their maintenance, and with the failure to achieve prosperity in general terms, which can manifest through the difficulty in obtaining a job, a business failure, destruction of agricultural production, among others. Contrary to the conclusions of Passador (2011), the fieldwork associated with this investigation clearly distinguishes the illnesses associated with the "diseases of tradition" and with witchcraft, the latter being the one that usually culminates in a rapid and unexpected death. As this investigation is not focused on witchcraft, we must bear in mind that the analysis of the interlocutors' discourses leads to a recognition of the contributions of Jean Comaroff (1993, p. 3), who considers the contemporary witchcraft as a modern manifestation of uncertainty, a moral unrest, and uneven reward and aspiration at the current time. The personal stories found about witchcraft have a common narrative structure and seek to reverse the economic status and distribution of power in interpersonal relations. It is relevant to know whether the usual designations of envy and social greed mean we are facing processes of social levelling, redistribution, and justice (Milando, 2007, p. 95; Fisiy; Geschiere, 2001, p. 227), to the extent that accumulation is always considered an individualist act ("eat alone") (Passador, 2011), in which the success of some implies damage on the others.

According to the local world-view, seizures and their violent manifestation – sudden and involuntary contraction of muscles – refer to various etiologies that, according to Guiliche (2002, p. 49), can be divided into: *kutsivelela*, the lack of reception ceremony for the newborn children in the family (presentation to the living and to the dead of the patrilineal lineage); *kuphalha*, the punishment from ancestors resulting from the lack of familiar ceremony or disagreement regarding the assignment of a name to a child[14]; and, in addition, *kuthankiwa*, social sanction due to theft, adultery, or murder. In the qualitative research, conducted in Chókwè, there were reports that, during the seizures, they placed the children on the ashes of the bonfire used to cook, so as to avoid contact with their urine and feces, which transmit the seizures (Bingham et al., 2012, p. 5), which are, locally, interpreted as belonging to the sphere of intervention of the *tinyanga* (Baume et al., 2000, p. 1498-1499; Okeke; Okeibunor, 2010, p. 65-66).

The "moon disease" was often referred to and usually associated with children (Bingham et al., 2012, p. 5). However, if no preventive measures are taken during childhood, it can also manifest in adulthood. Being a traditional disease, the most frequent expression to define its signs is "the child falls, gets scared, and has fits". *Nyoka* is the word, in *xiChangana*, which refers to a snake[15] (also used as a synonym for worms) and is believed to be the causative agent of "the moon disease", being found in the digestive tract, from where it can affect other parts of the body (Straus et al., 2011, p. 6). The fieldwork of Edward Green in the Gaza Province, with the *tinyanga*, concluded that all people are born with *nyoka* and this is awaken when impurities and filth accumulate in the body (Green, 1996), causing the disease *nyokani*. When the *nyoka* is disturbed, its manifestations occur in the person, the seizures being related to the phases of the Moon (Edward, 2007, p. 5). As it is not considered a "disease of the hospital", the preventive treatment (*dlanyoki*[16]) can only be obtained through a *nyanga* or from older relatives.

According to the contacted biomedical providers, the overlap between the "moon disease" and malaria, complicated and cerebral, is a cause of the delay in going to health services, since the mothers begin the traditional treatment, at home or with a *nyanga*, and only afterwards resort to a health center. If cerebral malaria is confirmed, this delay can lead to brain damage, situations of severe anemia and, in drastic cases, death.

In addition to the delay in receiving health care, sanitary technicians themselves have stated that it is necessary to wait a few hours before they administer antimalarial drugs, blood transfusions or other therapies due to the action of traditional remedies, administered by the *tinyanga*, relatives or acquaintances, in patients. Based on previous experiences, they fear there may be an intoxication by accumulation of medication at a time when the immune system is weakened. In contrast, in the study conducted by Langwick (2007, p. 89), traditional medical practitioners[17] advocate the use of syringes (injection in biomedical context) before the treatment of *degedege*, when an episode of malaria can have fatal consequences for the patient.

Symptoms shared between malaria and other diseases make the borders and categories that define the disease etiology and the type of provider to which resort very unclear and vague, and as a result patients and their families seek a complementary therapy between "tradition" and "modernity"

14 The definitions assigned by Passador and Honwana refer to the evocation of the spirits of the ancestors (Passador, 2011) and to an act of respect and permanent communication with the ancestors, which gives the group a sense of security and stability (Honwana, 2004, p. 258).

15 Concerning the association of seizures to supernatural causes, Bonnet (1986, p. 44), in relation to malaria in Burkina Faso, refers to seizures as "the bird disease". Muela (2000, p. 70) affirms that it is believed that *degedege* – the local expression used in Tanzania to mention malaria complicated or cerebral malaria – is caused by butterflies that surround a house and attack the children (Kamat, 2013, p. 108).

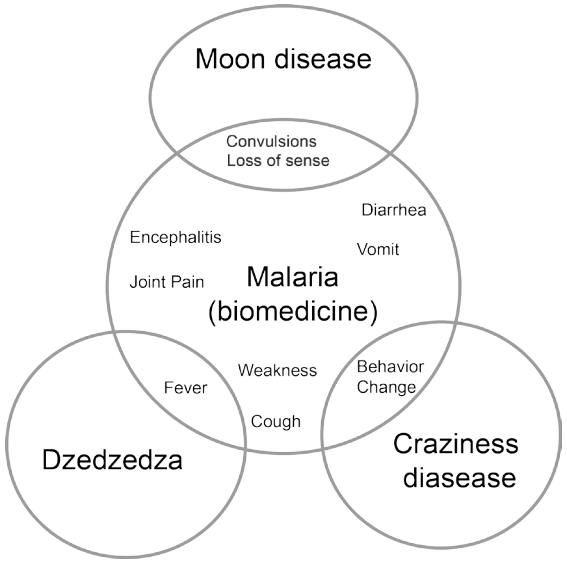
16 *Dlanyoka* is composed of a milk made from several crushed green leaves, which is ingested at dawn and at sunset by newborn infants during the first months of life. Given the extent of this practice across the country, the Ministry of Health has included, in its campaign on exclusive breastfeeding up to six months, a reference about the use of "traditional" medication in newborns.

17 The author resorts to the English expression "healers".

(Honwana, 2002; Passador, 2011; Meneses, 2004a *apud* Passador, 2011; Sequeira, 2015). The "moon disease", the *degedege* or other diseases of biomedical terminology that share the exterior sign of seizure, such as febrile seizure, meningitis, epilepsy and cerebral malaria, continue to have local associations of ancestral and spiritual nature. Both in the District of Chókwè and in other geographical contexts, health education campaigns that emphasize the resort to biomedical care have achieved very small results (Spjeldnæs; Bjørn, 2010). In the lectures of sanitary technicians and nurses, the "moon disease" is equated to the cerebral malaria and mothers must resort to biomedical health care, the local perceptions about the seizures are more complex and profound than a mere replacement of terminologies[18].

In addition to the overlap of significances between the "moon disease" and malaria, with the common sign of seizures, the relation between *malaria* and the "craziness disease" (considered a "disease of the tradition") was also recurrent, usually associated with a discourse that is meaningless and offensive to those present.

Figure 2 – Shared signs and symptoms among the various ethnodiseases and malaria



In short, Figure 2 expresses the complexity of possible terminologies and translations for malaria found in the Chókwè society. Through the reports collected, we had access to the reconfigurations that the local identification and diagnostics have faced due to greater contact with biomedicine, resulting from the expansion of biomedical services and from the natural calamity that affected Mozambique in 2000.

At the local level, the identification of *malaria* by the presence of one or more of the signs and symptoms described becomes complex, because this terminology has recently been integrated into the local lexicon and, moreover, it shares the signs and symptoms with other three ethnodiseases and other biomedical illnesses.

Discourses on the role of the *nyanga*

Traditional medicine is one of the ethnomedical systems present in the Chókwè society that refers us to the pre-colonial period and to the strategies and resources developed by the societies to face the disease and health. According to Baquar (1995, p. 140), one of the events that have contributed significantly to the development of traditional medicine were the moments of military conflicts between ethnic groups, in which plants enabled healing illnesses and injuries derived from such confrontations (Honwana, 2002; Passador, 2011).

The *materia medica* (ingredients/compounds of medicines) used is composed of leaves, roots, seeds, fruits, bulbs, bark of trunks or branches and sap, that are handled and processed (sometimes mixed with vegetable oils and animal fats) for human application. The use of medicinal plants is sometimes accompanied by rituals that involve the chanting of traditional songs, the use of amulets and other protections in the homes and the burning of incense (Baquar, 1995, p. 143). However, traditional medicine is not limited to plant, animal, and mineral elements. Since, in the African worldview, disease and misfortune may have different etiologies, such

18 See Nichter (2008, p. 44) on the introduction of new knowledge and practices in health campaigns and their effect on local knowledge and practices.

as the breaking of social taboos, the breach of obligations with the ancestors and witchcraft, there is a sum of knowledge and practices that refer to the maintenance of order and balance in the social sphere of the lineage (alive and ancestors). There is a body of knowledge and practices that operate in the maintenance of that order and integrate various symbolic significances (Fialho, 2003, p. 128) that, when manipulated and reconfigured according to the reality experienced by the group and its constituents, will result in a strengthening of social ties (Fialho, 2003, p. 131), in "domestication of uncertainty" (Granjo, 2009) and, for some of my interlocutors, in a conflict between "tradition" and modernity.

The relationship between patient and *tinyanga*, which, "at that time", was characterized by trust, concern for common integrity and welfare, became the provision of a service, subject to the rules of the market – opportunity cost, logic of supply and demand, specificity of the service provided and customer base. Monetization, commodification of social life[19] and the high mobility deeply altered the *tinyanga*'s logic of health care provision. Before, charging for the service provided was carried out after the family of the patient had seen the effectiveness of treatment proved.

During the colonial period, various reports state that the mode of payment for work adopted by the *tinyanga* was based on the exchange of goods, such as chickens or corn, and those who had access to currency would pay with it.

Currently, one of the main criticisms directed to the *tinyanga* is the fact that their services are very costly, being compared with the compensation practices to which some of the interviewees were used during the colonial occupation and post-colonial period. On the other hand, there were also reports of lack of compassion in relation to the situation of disease and lack of solidarity in relation to the lack of financial and material resources of patients who hire their services.

The rapid changes in social life and the breach of loyalty and obligations in relation to the group are also reflected in the domain of witchcraft, in particular in relation to censure to the *modus operandi* of the *tinyanga*. No longer considered elements of union, members of high status, and keepers of the community, they are now considered destroyers/predators of the common good and of individual life considering the payment conditions they require and the feeling of "dead end" that they convey to customers. Thus, if a misfortune/illness is diagnosed as part of the traditional sphere ("disease of the tradition" or witchcraft), the patient and respective family may not find alternatives, given the excessive monetary requirement to perform the treatment and the probability of therapeutic failure. In such cases, people are faced with the dilemma of either remaining sick and without possibility of cure or mortgaging their future by borrowing money from family or relinquishing cattle, usually saved for other social obligations, such as the *lobolo* and funeral ceremonies. As we shall see below, the zion pastors come to solve this dilemma and are the alternative to the conflict of interests and the decision of life or death.

The discourses related to the individualist nature of the *nyanga*'s management of their interpersonal relationships are extensive to the curative ineffectiveness of some of their treatments and the retention of customers in their home. Despite the *tinyanga* stating that, when they cannot treat a certain illness with their therapies (medicinal or spiritual), they advise the patient to go to the hospital, many of my interviewees stated that this decision is often late and taken after submitting the sick person to different traditional treatments and after the visible degradation of health. The repeated occurrence of these episodes resulted in several meetings between technicians of health centers, community leaders, District Administration representatives and *tinyanga*, so as to make the latter aware of the importance of timely transfer of patients. As there are no legal instruments that can attribute transgression or negligence to the therapeutic acts performed by nonbiomedical health care providers, institutions that promote health resort to these meetings to lessen the impact of the actions of these traditional caregivers.

19 See also Pfeiffer (2005, p. 257) and Passador (2011).

Another social criticism widely reported in relation to the *tinyanga* refers to them being promoters of conflicts within families, since, during the process of divination, they accuse relatives of "ordering" illnesses and misfortunes (witchcraft) to other members of the lineage. According to my informants, many of these accusations were considered unfounded and arbitrary, disregarding the existing family ties and loyalties. On the other hand, the arbitrariness that is attributed to the processing of the divination was indifferent in relation to the components of the lineage, their status in the social hierarchy or their contributions to the group, and any of them was subject to being accused of having the other bewitched. The diagnosis issued by the *tinyanga* is often considered irrevocable and assigned an absolute character, especially if a relationship of trust has already been established and positive results have already been obtained from the nyanga consulted.

If there is any doubt about the diagnosis, and if the family of the patient has economic conditions, another *nyanga* can be consulted. The second one will confirm or rule out the initial diagnosis. Honwana (2002) identifies three consequences that emerge from consulting many *tinyanga*:

> 1) more *tinyanga* have access to customers and the patient has to pay two or three consultations to solve the same problem;
> 2) the knowledge and powers of the *nyanga* are diluted and weakened, because their diagnosis becomes increasingly questionable;
> 3) the *tinyanga* may, occasionally, choose to present less accurate and more vague diagnoses to conform to the expectations of the patient and ensure his or her return in the future (p. 73).

When some randomness is recognized in relation to the victims of acts of witchcraft, the interlocutors recognized the same arbitrariness in the accusation by the person who is in their origin, through the diagnosis made by the *tinyanga*, especially when this involves members of the same lineage or elements that inhabit the same yard (family members who do not belong to the same lineage, or people who for some reason live in the same yard[20]). However, this arbitrariness does not remove the accusatory effect and the social stigma that is attributed to the individual and respective group (lineage and elements that inhabit the same yard), sometimes contributing to family breakdown – divorce of husband and wife, split of siblings, abandonment of the elderly – or, in extreme cases, to the lynchings considered privatized justice (Serra, 2008). This unpredictable arbitrariness leads to the vulnerability of some social groups, such as elderly widowed women who, by living in the yard with their sons and daughters, in-laws, and grandchildren, see their social status be diminished and are, at times, discriminated against within the group, having to ensure their own livelihood[21].

The increasing mobility and concentration of population in certain places contribute to a higher number of *tinyanga* and make it difficult for them to be known and recognized by the community, resulting in less trust in their therapeutic processes and causing both disputes for power among the *tinyanga* and for the attention of potential customers.

These conflicts are also associated with the harm to others, either through the "ordering" of a hex or because a diagnosis unveils the identity of the promoter of the witchcraft act. According to the interviewees, these conclusions are characterized by a great arbitrariness and disregard for the social status and social position of the individuals within the group.

As has also been mentioned, the *tinyanga* play an important role for those seeking protection for future projects that present risk and danger. The reports collected in the district of Chókwè mentioned this practice by Mozambican emigrants seeking new opportunities in South Africa, some of legal and other of criminal nature. Some *tinyanga* also reported that several political heads of their village and of the city of Chókwè were frequent customers.

Based on the diversity of motivations that lead patients/clients go to *tinyanga*, it becomes evident

20 We found cases of long-term visitors, people who rented rooms that were located inside the yard and employees of some of the members of the lineage.

21 About the "evils" attributed to women in the society of Homoíne, see Passador (2011).

that these have access to much information about their communities, the tensions and conflicts that exist between people and their plans for the future. This double power over another (knowing about the other and the possibility of taking action against the other) makes the *tinyanga*, also, feared and repudiated members.

These discourses about the *tinyanga* must also be considered in a context of strong Christianization of society and demonization of the *tinyanga* as a source of misfortune and the antithesis of a good Christian. Nevertheless, of the reports collected during the fieldwork, many mentioned that the consultation with these traditional therapists is always conducted at night, so the identity of the patient/client is not disclosed publicly and, thus, he or she is exposed to local interpretations and judgments, as well as to the risks that may be involved.

In the negotiation at the time of consultation with the *tinyanga*, as with any other provider, the liking and agreement of the patient/client are not considered (Langwick, 2007, p. 112), but rather the interpretation that the *tinyanga* makes of the resulting benefits and well-being. In short, the individuals take a purely pragmatic decision, which results in a personal dilemma between their beliefs and knowledge and their success and well-being.

Discourse on the pastors of zion churches – "Healers with a Bible?[22]"

Some of the churches in the District of Chókwè have an important role in providing health care to their believers and to individuals of other faiths. Although Christian missionary churches (Catholics and Protestants) have had, during the period of colonial occupation, a "civilizing mission" in the contact with local populations (Cruz and Silva, 1992) – including the provision of biomedical care –, since the beginning of the 20th century to the present day there is a growth in the number of African independent churches and Pentecostal churches, whose members in the top of the hierarchy conduct healing practices, resorting to traditional medicine and/or spiritual healing.

The zion churches[23] include in their religious practices elements of African "tradition" and recognize the existence of the ancestors and of evil spirits. However, they assume a total rejection of the *tinyanga*, since, for the Zionists, they personify evil and misfortune, being considered the antithesis of God, harmony, and health[24].

For the Zionists, those designated herbalists (*tinyanga* who only use plants and roots and that do not evoke the spirits or use the *tinhlolo*[25]) do not constitute a threat to the order of society and may even be members of the zion church. However, the remaining *tinyanga* are considered, by the members of the zion churches and their pastors, as mediators of miseries and misfortunes.

Several interlocutors mentioned that the *mazionex*[26] cure illnesses related to witchcraft (but they can also be in the origin of acts of witchcraft), use plants and roots in their treatments, as well as ash and roots. The members of the zion churches knew, unanimously, how to declare the conduct of therapeutic practices and spiritual cures.

In a context in which biomedical health services have a reduced coverage, and given the numerous criticisms directed to the *tinyanga*, the followers of zion churches, motivated by the cure of an illness or case of witchcraft, consider these churches the "best solution" at the local level: strong community

22 Expression used by interviewees.

23 The term zion churches will be used in the plural, since there is a wide diversity of worship, healing practices and food taboos that are not shared by all pastors and believers who attend congregations with that designation.

24 About the zion churches, see Comaroff (1985), Oosthizen (1992), Niekerk (1992), Agadjanian (1999), Mahumane (2004), Grundmann (2006), Goudge (2009), Kamp (2011), Cavallo (2013).

25 The *tinhlolo*, or "throw of stones", in translation to English, consists of a set of shells, *canhu* seeds, bones of various animals (such as goat, zebra, giraffe, kudu) and turtles' dorsal carapace scutes that are thrown by the *nyanga* on a dry skin of goat.

26 Term used in local slang and in *xiChangana* to refer to members of the zion Church and its pastors.

connection[27], consolation, reciprocity, and positive therapeutic results at low cost.

The advantages of syncretism referred previously are evident to members of the zion churches and to those who go to it in the hope of a solution for an illness. However, most interlocutors, in associating the *mazioneś* with the *tinyanga*, assume a defensive attitude with rejection, because both are related to evil spirits, misfortune, and illness. This is a recent phenomenon and expresses the dissemination of zion churches in southern Mozambique and, in particular, in the District of Chókwè.

This religious community with therapeutic practices is commonly known among the local population, although sometimes there may be a lack of knowledge concerning their rituals. In interviews with health professionals assigned to health centers in remote areas, the opinions and experiences are divided into three categories: those who know of their existence, but mistake them for the *tinyanga*, maintaining a weak collaboration with them; those who are unaware of the existence of "churches that cure diseases"; and, finally, those who know the Churches and their practices.

In an informal conversation with one of the persons in charge of the biomedical health care provided in the District of Chókwè, it was stated that the existence of churches that cure diseases was a total novelty, although, indirectly, there had already occurred a conflict with a pastor of a zion church that was thought to be a *nyanga.*

The local societies in which these providers operate accuse them of practicing witchcraft and of contributing to disorder, conflict among family members and communities, and of endangering the lives of patients who they supposedly want to heal (the same type of account was collected about the *tinyanga*). Biomedical services and their technicians exercise their activity isolatedly, with little engagement and barely knowing other health providers that may exist in the perimeter of their action. The other international organizations are unaware of these actors and remain faithful to guidelines for intervention that disregard the local dynamics and specificities.

The zion churches and prophets, as modern health care providers, with an ambivalent and porous identity to some and unknown to others, reflect the dynamism of the African religious and social movements. Religious membership and praxis are a guarantee of protection from afflictions, from evil spirits, from witchcraft, and from illnesses, and the pastors of zion churches, in performing the spiritual healings and resorting to traditional medicine, contribute to the social construction of diseases and reinterpret the cosmological knowledge. This reinterpretation of knowledge occurs in the relation of believers with their ancestors, in the exercise of social roles acquired, and in the social relations established between the believers and the rest of society.

Discussion

In seeking to understand the various local interpretations on this disease, either of the various health care providers or of individuals, it was found that malaria is, currently, classified as a "disease of the hospital" by most interlocutors. However, this designation is not limited to fixed and exclusive significances. On the contrary: the diagnosis of malaria and the initiative of seeking treatment are influenced by economic factors, organizational factors (ethnomedicines and existing providers), and relational factors (social status, prestige, and political connections). In this sense, the knowledge of the nonbiomedical providers available in a society is essential for patients who seek healing of their illnesses, within their worldview and the limits of their beliefs.

In the current economic context and with the expansion of the charismatic Pentecostal Christian churches that are contrary to the maintenance of beliefs and therapies considered "traditional", the *tinyanga* are demonized by misfortunes caused,

27 In the case of patients who seek help in the churches, the compliance with the instructions of the pastors, associated with the suffering inherent in their condition, transforms the relationships among believers in relationships among brothers (a term referred to repeatedly by respondents). In addition, as was also observed in other Christian churches, the encouragement for participation of believers in the rituals, meetings by age groups, visits to houses and patients, the choir, cleaning of the Church, monetary contributions, among others, strengthen the community experience.

allegedly arising from their practices, regarded as witchcraft. Contrary to the discourse of yore, nowadays they are considered elements of social breakdown, more focused on their direct gains ("individualism") than on their healing missions. In the current context of therapeutic pluralism and high mobility, the lack of sensitivity and compassion attributed to the *tinyanga is* due to the commodification and monetization of their medicinal knowledge and rituals, as well as to the competition with other providers in attracting patients.

Although most religious institutions in southern Mozambique are not willing to perform therapeutic and spiritual practices, zion churches attract a significant number of believers, mostly because of their healing rituals. These churches value traditional beliefs, recognize the importance of the relationship with the ancestors, and reproduce some of the treatments carried out by *tinyanga*. However, they differ from them, as they invoke the aid of the Holy Spirit and the acquisition, through divine intervention, of spiritual gifts[28]. As in the case of the other Christian churches, zion pastors also condemn and advise against going to the *tinyanga*, who, according to them, enrich at the expense of misfortune and misery of others. To followers of zion churches, motivated by the cure of an illness or case of witchcraft, these religious institutions are considered a therapeutic alternative at low cost with a supporting religious community base.

These actors consider one another as rivals, and only in certain cases their cooperation can be observed. Biomedical providers, either being representatives of the State or of the civil society, refrain from participating in these relations at the local level, having a very superficial and stereotypical knowledge of their practices. The social construction of illnesses, such as malaria, and of the social relations between providers and patients must be central in the planning of public health actions. The provision of health care that ignores these internal social dynamics and that establish no dialogue with their key actors may be at risk of being limited to itself and of disseminating health education messages that are out of context. Moreover, at a time of major changes in the treatments used, in the diagnostic technology, and in the biomedical knowledge about malaria, it is essential to have a strategy of community dialogue and mobilization that can respect the ethnomedicines and their actors. Thus, any initiative on malaria control (prevention, education, diagnosis, and treatment) should establish a dialogue with the local knowledge, practices, and actors, the State (Ministry of Health) being responsible for mediating these relations.

Conclusion

The knowledge and therapies adjust to sociocultural dynamics, in close relation with acquired habits. At the level of health policies, the local traditional providers are, at times, unknown and relegated to invisibility (zion pastors), and at times they assume a subordinate role (*tinyanga*) in Public Health policies, in association to the extent of a funding coming from abroad and promoted by biomedical providers who think they can decide on the action of the *tinyanga* in the field of Health. The superficial knowledge and an approach of the *tinyanga* motivated by international agendas and external biomedical actors (Non-Governmental Organizations, United Nations agencies, multilateral organizations etc.) should take as its starting point the creation of a space of dialogue, mutual knowledge, and sharing of experiences. Otherwise, biomedical practice and clinical conduct are dissociated from the reality in which they are inserted.

Implementing health policies that meet the local diversity, the power relations, and the medical knowledge and practices may reinforce the biomedical care provided and harmonize the relations between providers and population. Possibly, if when the introduction of the new line of malaria treatment and the massive distribution of Rapid Diagnostic Tests for malaria across the country occurred (2008/2009) there had been a greater community

28 The zion pastors have the ability to invoke the Holy Spirit to effect the cure (Agadjanian, 1999). The power of the Holy Spirit upon the traditional spiritual forces defines the dialectic relationship between health, well-being, prosperity and Pentecostalism, and the illness, misfortune and the compliance with the "tradition".

involvement and clarification, patients and their families would not have seen their health knowledge and practices questioned (Sequeira, 2015). Unless people see their questions clarified, new knowledge and practices will emerge based on the experience with biomedical services. These new domains may strengthen or weaken the biomedical services rendered and the malaria control plans for a certain area.

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