In sickness and in health: experiencing medical spaces in Mbarara (Uganda)

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IN SICKNESS AND IN HEALTH:
EXPERIENCING MEDICAL SPACES IN MBARARA (UGANDA)

A Thesis
Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Master of Arts

in

The Department of Geography and Anthropology

by
Kara E. Miller
B.A., North Carolina State University, 2006
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Abstract

This thesis is a contribution to cross-cultural studies on health and medicine explored through the material and symbolic facets of health care in a region of Southwest Uganda. Research conducted in the healing spaces of Mbarara reflects traditions in the anthropology of the body and brings a lived perspective to conditions of sickness and wellness. By tracing the biographies of treatment spaces, the medical landscape is evaluated in terms of participants’ perceptions, convictions, and knowledge sets. Phenomenological methodology is employed in this exploration of ill states and curative places, which braids concepts and academic work in the areas of medicine, space, and the body.
Introduction

Perception begins in the body and ends in objects.
- Thomas J. Csordas, Embodiment as a Paradigm for Anthropology, (1990: 9) (paraphrased)

Outside and inside form a dialectic of division.
- Gaston Bachelard, The Poetics of Space (1958: 211)

Illness and dis-ease are experiential bodily conditions that manifest and move through bodies and spaces, and are shared through communicative disclosure or visual signs. This thesis explores embodiment of physical and psychological illness, as well as systems of healing, in a region of Southern Uganda as interpreted through expression and material culture. The phenomenological reality of illness is a personal experience existing within an individual and observed through symptoms and states of being. Being-in sickness, as conceived by Jean Paul Sartre (1956,) is a state of being conscious of self and context, which leads to a practice of interdependence within a world that we activate (Richardson, 2003). That world is composed of and fabricated through the spaces that we inhabit and the material expression of our experiences. I explore spaces of healing in the Mbarara region as constitutions of ideas regarding illness and representations of remedies.

The present work builds on anthropological reflections on human experiences through an examination of health and medicine. I look to Victor Turner’s (1986) foundational theory that welds experience and expression, and to phenomenological perspectives set in motion by thinkers like Husserl and Heidegger, to engage a discourse on sickness and cures in and out of spaces and bodies.

I am inspired by Susan J. Rasmussen’s (2000) work among Niger’s Taureg healers as I attempt to weave together three fundamental notions in the study of human
beings: health, space, and the body. For each of these spheres of lived experience, I harness the concepts of inside/within as opposed to outside/without to describe circumstances of illness, encounters with care, and treatment choices. My work aims to recognize and convey what being in-sickness versus being-in-health means for participants in Uganda, and I try to understand these realities by engaging the curative landscape, observing the spaces and interpreting the narrative revealed to me. The menial and the poetic aspects of place and dialogue play into my interpretation as I translate discussion, observation, and phenomenological experience as realized through symbolic and materialized, as well as verbalized, thought, which I refer to simply as expression.

Thematic Chain

Expression and experience compose the bridge between phenomenological existence and evident material objects. Edward M. Bruner’s eloquent homage to Turner on the subject of experience reads that experience is the inner, primal, living, embedded, constructed reality that is extended through expressions, which are witnessed as “crystallized secretions of once living human experience” (Bruner 1986: 5). Turner admits that “meaning is hard to measure,” but that we come closer to meaning by “redressing” what we see, know, and believe as art and behavioral performance (Turner 1986: 33, 41).

Experience and expression are interrelated concepts by which we gain knowledge of self and reciprocate our worlds. Setha Low writes that expressions, such as metaphor and other “figurative language,” merge our sensations with our understandings (1994: 139). She calls this the “paradigm of embodiment grounded in perception and practice,” whereby we express experience and convey that which is felt yet perhaps unseen (1994:139). Notions of embodiment apply to the spaces and the practices in which we
engage where we internalize material symbols and surroundings, as well as to our
embodying, taking in or transforming through, illness. Our bodies are the centers by
which we experience and navigate our worlds, and those bodies literally and figuratively
absorb as well as express material culture.

Material, as the expression of experience, provides insight into lived perspectives. The anthropologist has the role of interpreting material and inferring the lived perspective, but we use ethnographic data to back up and inform that view. The material landscape is the collection of ideas and activities of people within, and serves as the constitutor of space; it is the manifestation, or artifact, of activity, and it comes to symbolize thought collectives. The material world is created and activated by our existence, and, in turn, structures our lived and sensed realities. When we interact with material, we put life into it, and allow it to act on us. Barbara Bender considers the cultural landscape to be marker and demonstrator of peoples’ activities, and she says that the landscape “talks back,” (2006: 303). Material expressions contribute to the character, utilization, and interaction in and with spaces, act as indicators of inner happenings, and articulate thought. Paul Stoller writes that, from a phenomenological approach, “observers and/or actors are no longer in space, but constitute it through the dynamic actions of their consciousness” (1980:427). We create our worlds with expressive materials, interaction, and behavior, but we do so in reference to the spaces, people, and things with which we interrelate.

Material can represent action and behavior, but can also be imbued with character. Material carries power, intention, and feeling directly through messaging and expressive means but also through more nuanced affections, and acts on the body on at least three
levels: physically/biologically, interactively, and symbolically. Janet Hoskins explains that materials have agency and life histories as they survive or change context, and inspire owner, user, or viewer (2006: 74-83). She gives lives to material objects and images, and I attempt, similarly, to give character and consciousness to spaces, as they are experienced, sensed, read, and felt, considering the active properties of a space.

A space and its components communicate to a medical consumer through apparent material presence, but also through more elemental, phenomenological feeling. A clipboard may indicate officiality and power dynamics; but a cold, dark space, for example, has emotional attachments and may trigger profound connotations. Engagement with medical spaces and practices introduces the histories and intricacies of that practice into the consumer. The term, consumer, I find appropriate for a discussion on medical embodiment and engagement in place as one consumes both treatment and knowledge. This notion is inspired by the work of medical anthropologist, Anne Lovell (1997) and her work with participants in healing infrastructures and social constructions of illness.

Consciousness and character are understood as existing within material objects and embedded in spaces. The sense or sentiment of a place can transfer to the body through passive or active embodiment. Thomas Csordas uses the notion of embodiment to move beyond representation and symbol, and into experience. He brings bodies to the forefront of the discussion on being-in by claiming that experience starts in the body, and he negotiates the science of phenomenology by arguing that the body’s presence in space inspires a sensory and social existence, and therefore constitutes a reality (1994: xi-11).
Bodily experience is the fundamental nature of our encounters with the world, and spatial dynamics outline our felt and known realities. Michael Jackson emphasizes the body as alive and as lived. His work contributes to the present piece by offering theories of a, “body praxis,” which aim to illustrate that “human experience is grounded in bodily movement within a social and material environment” (1983: 330). Bodies in place prompt reactions and interactions where we feel, internalize, and navigate our worlds.

These interactions are aptly explored in terms of medicine and health. Humans attempt constantly to manipulate material to affect bodies, and we rely on the pragmatic or sacred properties of medical material as we pursue effect. We also demarcate and seek out spaces of treating and influencing the body.

Places of health care and treatment are evidence of our organization of medical knowledge and applied medical techniques, as well as our concern with functional and well-understood bodily existences. Baer, Singer, and Susser harness the concept of illness

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1 Jackson argues with Mary Douglas and others who have conceived of the body as representational and made up of symbolic pieces. Though I agree that we should go further and see the body more dynamically and experientially, I also believe that embodied practices are carried and performed through the body, such as in the case of infectious mannerisms between close company, or scars.
networks as part of a discourse on cultural interpretive medical anthropology. They write that, “Disease is knowable… [if] only through a set of interpretive activities,” which “involve interaction of biology, social practices, and culturally constituted frames of meaning” (1997: 25). Societies rely on symbolic communication and exchange to make sense of and deal with perplexing bodily conditions. Byron Good wrote that humans give names to experiences and conditions to make meaning through “semantic illness network[s]” (1994: 171). These networks include shared knowledge of medicine, symptom narrative, illness experience, and sickness construction, and this management involves spaces of treatment and cures.

In states of illness, people realize a presence in time and space and embody a specific domain. These states are particularly illustrative of phenomenological reflection, because they place us in bodily conditions, which affect our lenses and our abilities, and therefore affect our perceptions and our presence in place. Emiko Ohnuki-Tierney (1980), working with Ainu peoples of Sakhalin Russia, states this idea most clearly. She writes that perceptions of sickness and discomfort are “systematically related to [the Ainu] spatiotemporal classification of the universe and to other aspects of their basic perceptual structure” (1980: 132). In this way, the sphere of sickness becomes a space that people embody and that informs general outlook. In terms of being within a sphere of illness, I turn to recent work by Swedish philosopher, Fredrik Svenaeus, who writes about the phenomenology of falling ill in terms of the embodiment of discomfort and suffering, which leads to self-evaluation (2009: 60). In times of compromised ability and health, we tend to become hyper-aware of our capabilities as well as the delicate nature of our bodies. Sartre (1956) muses about illness as a certain “melody,” that Allan Young claims,
throws the “more or less uncritical acceptance of life,” up in the air (Svenaeus 2009: 57; Young 1982:275).

Beyond a bodily domain of illness, which involves certain emotions and conditions of self-analysis, sickness often spurs an outward-looking navigation of recognized spaces of curing and treatment for answers or aid. Conditions of illness push us to resolve issues in our bodies and in our worlds. We seek to feel and function better, and we often seek to find the origins of our affected conditions. Arthur Kleinman writes that experiences of health conditions and suffering are “embodied, evoked, realized, and actualized in somatic processes like *habitus* and in symptoms” (1997: 323). By studying the perceptions surrounding illnesses and the dealings with symptoms, we may come closer to understanding the lived state of sickness.

Humans have ways of communicating bodily conditions and understanding one another’s sensations, and we have paths of health pursuits to deal with maintaining and strengthening our bodies. Allan Young and others emphasize the social definitions and structures that help us deal with illness and affected bodies; others, like Sjaak van der Geest and Susan Reynolds Whyte, emphasize our attraction to medicines, medical material, and medicinal objects (Young 1982; van der Geest and Whyte 1989). Knowing illness prompts us to understand how people conceive of a disease and the diseased self; it also requires that we grasp the allure of the cure.

It is the confining realm of pain and the pursuit of livability that lead peoples to treat and alleviate. Medicines not only prompt physical reactions, but also help to place pain, stress, and instability on some other, often tangible, thing. Medical material stands for action and generally represents healing. Medicines, either physically or symbolically,
are the cure, the path, or the carriage to come out of a sickened state. “Medicines change the state of a person, either by curing, protecting and empowering, or for victims of witchcraft, by weakening, draining and poisoning.” (Maia Green 1996: 488). In various forms of intake, medicines react with the body and are meant to move the body from a specific state to another.

Participation in healing practices and engagement with medical material are activities and behaviors that are indicative of a realized bodily condition and a pursuit within an acknowledged social system. States of dis-ease or of malfunctioning bodies are bodily spheres that we enter, or fall into, and are often clearly defined in opposition to healthy existential positions. Medical media enliven sites of curing practices and shape sickness categories. Medicines can be the passage between illness and wellness, and the means for constructing the distinction between these states of being.

**Succession of the Following Sections**

This paper looks to spaces of healing in two primary care venues of rural Uganda (government clinics and small, personal practices) in order to appreciate the role of the spaces in the experience of dealing with ill health and to understand how those seeking care in each may feel. The present work reflects the pragmatic and the cosmological approaches to illness and health-seeking within the district of Mbarara in an effort to highlight the lived experiences of ill states and bring experiential perspectives to a discourse in medicine. I hope to convey the experiences of the people represented here through exploration on how spaces, bodies, and medicine overlap and interact.

Because I aim to present theories of being in the world, my mission herein is to take the reader *into* the spaces where my research was carried out. So, the first chapter,
Machines and Mirrors, is description that I hope will walk the reader through the health care spaces as I see them and through what I believe to be communicating factors therein. This description is coupled with photography and diagrams that I think will take the reader through the locations that I have studied. It is a purposeful move, on my part, to reserve analysis for the next section, so that, for a moment, the stories and the spaces speak for themselves.

In Chapter 2, Navigating Medical Realities, I use exemplary interpretations of the spaces to demonstrate levels of engagement in place. I look to embedded signs and messages, yet it is not my intention to reduce the spaces to theaters. I emphasize expressive culture in that which is affixed to spaces as symbolic of what and who is being represented, as well as the inner happenings of a place. Hilda Kuper writes that sites such as social spaces or scenes of interrelations are, “symbol[s] within the total and complex system of communication,” and that we must try to see the “qualifying and latent meaning,” by considering the interplay in social spaces (2003: 258). In this section, I try to understand cognitive structures of illness and categorical networks of healing based on practical pursuits of care in medical spaces. I trace navigations through and boundaries within the medical landscape to see the perceptions and preferences of participants as well as ideas about the nature of various diseases.

**Boundaries**

Vishvajit Pandya follows Bourdieu and others who acknowledge space through movement and boundaries. Pandya claims that “the conjunction of spatial categories [and] social practice creates boundaries of space, “ and he calls for ethnography that highlights space as “an embodiment of a system of meanings” (1990; 775-76). I
emphasize the idea of boundary, as an imagined threshold, which is created by human practices and mediated by human perspective. Boundaries in space and boundaries of the body are incessantly broken by one another, and in this interaction lies activated being-in and embodiment.

Chapter 3 is where I apply the concept of being-in (space/ the world⁵) to the sphere of sickness, which I claim is an encompassing place with boundaries. This section, Being In Illness: The Sphere of the Sick, like the first chapter, contains a break in textual form, whereby I expose the reader to a flow of narrative that can be read in order, completely, partially, or backward- at the reader’s discretion. Rather than follow the formulaic quote-analysis pattern found in many ethnographies, I have chosen to allow the reader to be exposed to a stream of sickness biographies and body commentary. In this way, I again share with the reader my own experiences in the field, where as a privileged foreigner among the sick, paining, and afflicted peoples of these communities, I was a source for venting troubles and a perceived avenue for relief. This narrative flow will hopefully put the reader in to the spaces of health care, where assertions of self and sickness emanate. I would like the reader to simply take in these complaints and confessions, as these are Mbararans’ portrayals of illness experiences. They help define what illness means in the Southern Uganda context and give insight into the lived conditions.

The counterpart to sickness is medicine, and I argue in Chapter 4, Tablets and Injections, that materiality is key in the allure of medicine. Materiality is a central theme throughout the work, but comes out most clearly here, through discussion on medicinal

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² See Martin Heidegger’s Being and Time, 1962, or Miles Richardson, 2003.
media, the object-ness of medicine, and the active qualities of medical spaces. Chapter 4 presents some imagery pulled from healing spaces and explains symbolic means of curing. This chapter will highlight the elusiveness of some cures and the attracting power of healing.

**Style and Methods**

I see this ethnography as an extension of what as been articulated to and interpreted by the anthropologist, to her readers. My intention is that through a transmission of experience, I can carry the sensuous and the mundane qualities of place one move further to allow the reader to see and feel the surroundings that I have seen and felt. Bringing the reader into my own sensed understanding seems appropriate to a discussion on being-in-the-world and the anthropology of experience.

I am more than encouraged by foundational work in anthropological explorations of experience, and I turn to Clifford Geertz for support in my stance. He writes, in an epilogue to *The Anthropology of Experience*, entitled, *Making Experiences, Authoring Selves:*

> It is at least one of the jobs of the ethnographer… to pay such attention, particularly to the means [of expressing selves]… We cannot live other people’s lives, and it is a piece of bad faith to try. We can but listen to what, in words, in images, in actions, they say about their lives… [for] it is with expressions- representations, objectifications, discourses, performances, whatever- that we traffic [culture.] (1986:373).

And although I work in a traditionally anthropological frame, I also try to move the ethnography into a place of performance and artful engagement by rearranging the usual format and incorporating diverse textual styles as well as sundry pictorial representations. The photographs and diagrams incorporated in the current work are meant to bring the
readers into space and into place, and I hope that this thesis is as experiential on paper as it is in my head.

**Discipline Dance**

I look to discourse outside of the discipline of anthropology to inform my endeavors in resituating ethnography. D. Soyini Madison works in performance ethnography, and in her 2005 book, *Critical Ethnography*, she pulls from traditions in communications and performance studies. Inspired by a forerunner in performance ethnography, Dwight Conquergood (2000) she posits that we can undo “scriptocentrism,” or a reliance on and privileging of text, by using the body as a tool and a vehicle for ethnography (Madison 2005: 166). Although she is mainly referring to physical performance and theatrical presentations, this viewpoint transfers to the written ethnography if the researcher allows her body to inform her data and her analysis. I believe that phenomenology does exactly this; studies done on the essence of experience and the lived body place information and knowledge into the self and the moving, interpretive body. By using my own engagement in place to inform the present ethnography, and through explorations in body-space dynamics, I hope to present ethnography that emphasizes bodily experience and performative realities.

Through the use of photography, narrative translations, and descriptions of a psycho-social landscape, I hope to achieve what Madison calls, “dialogic performance,” which resists the perpetuated mono-form textual methods that exists in much scholarly writing (2005: 167). One method of studying and evaluating culture that Madison teaches is that of “mimesis,” which she says refers to “performance as a mirror or imitation of experience,” (2005: 169). It is my intention to fully embrace this concept by presenting
ethnographic data that simply transfers ideas and information expressed to me, and which I observed, to the reader. I try to convey the experiences of others through description of place, imagery, and commentary flows. To this, I add my own emphasis and framing.

In, Tales of the Field, John van Maanen muses on the difficulties and the brilliance of interpreting reality. He refers to fieldwork as a “pursuit of culture,” and to ethnography as a tale, and as “hauntingly personal” (1988: ix). The voice of the author, as van Maanen discusses in his text, is a decidedly methodological stance that the author uses to “display the culture,” (1988: 13). Ethnography is intimate in many ways; researchers hopefully have close interactions with those with whom they work. Then, to carry personal experiences of places and people over to scholarly and removed audiences presents a delicate, challenging venture that, I believe, calls for and is conducive to interpretive, experiential presentations. I try throughout this thesis to bring my translation of experience through to the reader in order to provide the most accurate lived sense of Mbarara.

To embrace interpretation is to approach research and literature with an honest and lucid standpoint. I try, with the research presented herein, to understand the perspectives of Mbararans while moving those perspectives through my ethnographic translation.

**Why Phenomenology?**

I personally entered the field of phenomenology through studies in architecture and design, and it remains with me so that when I visualize space and movement through the world, I see human-scale objects, the built environment, and bodily procession. Why do thresholds feel performative and seemingly alter the bodily condition? It may have
something to do with cultural connotations, or perhaps this is due to the active properties of place. I believe that phenomenological perspectives both touch on the magic qualities of human consciousness and describe the most simplistic details of the everyday.

Phenomenology is both a philosophical course as well as a methodological tool for seeing and exhibiting lives, experiences, and cultures. From Linda Finlay’s (2009) text,

*Debating Phenomenological Research Methods*, we learn that the nature of research in phenomenology is both a return to basic depictions of place as well as a move beyond unchained, elusive, postmodern tendencies. She writes that research is phenomenological when,

> It involves both rich descriptions of the lifeworld or lived experience… [and] a special, open… attitude [that] sets aside judgments about the ‘realness’ of the phenomena. [It is] research [that] characteristically starts with concrete descriptions of lived situations… set down in everyday language [that] aims to go beyond explicit meanings to read between the lines so as to access implicit dimensions and intuitions… Here, phenomena are seen to be made up of essences and essential structures which can be identified and studied…Phenomenology can be seen as tending toward being a realist, modernist project where there is belief in a knowable world with universal properties… (2009: 8, 10, 15).

On the subject of research participants, Finlay explains that consultants “validate researchers’ analyses,” and that researchers must be careful, with creative, literary, and relativist work, to “ensure that they do not loose the speaking, experiencing subject,” (2009: 16-17). Researchers presenting their own experiences risk ignoring or doing an unethical disservice to those with whom they work. To avoid self-commemorative work and to honor research participants, ethnographers should rely on other methods of acquiring information for guiding our perspectives. I mentioned that I present my own
experiences, but that I do so in such a way that is informed by and structured by the
experiences with people of Mbarara.

Phenomenology is based on the concept that we can get to truth by fully
embracing and richly describing our surroundings, and basing our ideas about those
surroundings on experience. Thomas R. Lindlof and Bryan C. Taylor argue that, “Only
when attention is reflected toward the self does experience become meaningful,” but that
meaningful experience can and should be applied in social sciences, where “we gain
insight into people’s motives for action by engaging them through their acts” (2002: 36).
Human science “enters the gap,” of intersubjectivity through ethnomethodology that
focuses on, “the local construction of meaning through social- particularly
conversational- practices,” (Lindlof and Taylor 2002: 37, inspired by sociologist, Harvey
Sacks).

These authors (both working in communications studies, but bridging diverse
disciplines in published works,) pull from theorist, Harold Garfinkle, whose version of
phenomenology hinges on indexical cues to culture-specific ideas and data points
(Lindlof and Taylor 2002: 38). This methodological outlook offers that context is a key
resource, and that social interactions provide a setting for emerging expressions that
indicate perspective. In this thesis, I present ethnographic data gleaned from observation
of practitioner-patient interactions and social exchanges in places of healing that illustrate
not only people’s time and space-specific attitudes and thoughts, but provide insight into
deeply rooted views. Being in places of medical practice for the course of an operating
day, and listening to the interactions that go on in waiting spaces, where emotions and
knowledge collectives overlap, allowed me to hear the perspectives of those seeking care
and experiencing illness; doing this day after day allowed me to hear the background stories and understand ‘why’ those perspectives were in place.

Garfinkle proposes that reasoning and reality must somehow become visible, or perceivable, in order for social actors to share and communicate ideas (Lindlof and Taylor 2002: 39). In other words, we can analyze interactions and interpret realities through the expressions that come from personal and social experiences and the material fabric of the landscape. I look to expressions, in the present work, in rich descriptions of space and material culture, as well as analysis of symbolic features of the medical-scape, which I claim are indicative of experience and contribute to ongoing transactions with place.

**Fieldwork**

I gained the knowledge herein mostly through in-depth interviews and questionnaires geared toward understanding basic perspectives (thoughts, ideas, opinions, worries, and so on) of Mbararans regarding health, health care infrastructure, and healing methods. My involvement with health care in Uganda comes from an internship that I was awarded in the summer of 2009 through the Christian Brothers University (CBU) division of the Minority Health International Research Training (MHIRT) grant, sponsored by the United States’ National Institutes of Health (NIH). This research was the second phase of a long-term grant meant to improve access to and quality of health care in Mbarara, Uganda. Our research in this particular stage (2009) focused of preferences and perceptions of community members and health-seeking behaviors, and this focus took us to the sites of health care facilities where we spoke with consumers about their choices in
health care, self-treatment, preferences in medicine, expectations from practitioners, and beliefs regarding illness. The goals of the research at this phase were:

- to understand what people perceive as effective health care and what treatments are most efficient
- beliefs about certain illnesses and the factors that cause or spread disease
- what people consider to be the major health problems and challenges to healthy conditions in the area
- what types of care people prefer for these main health issues; likes and dislikes about various avenues of care
- what constitutes illness or sickness; when treatment is sought; when conditions warrant self-treatment and when sickness is considered dire

Through questionnaires, interviews, surveys, key informant discussions, observation, focus groups, and sessions of informal dialogue, we gained insight about people’s experiences. Our research group collected illness commentary, and invariably began to understand the viewpoints, convictions, ideas, and perspectives. By asking people about very personal conditions such as illness, childbirth, and suffering, and by opening conversations to allow self disclosure and uncertainty, we were able to see what sicknesses threaten people in Mbarara, how they deal with sickness, and how they view venues of medicine and care.

Themes of preference and categorization of health care sources in the surveys were meant to ignite conversations on the potential for cooperation between biomedical and traditional health care practitioners- a possible ultimate goal of the MHIRT program. Because we conducted interviews in sites of care, we were able to talk specifically about people’s current conditions and visits to spaces of treatment. This also meant that we received responses that were skewed by our presence at a particular place. Mostly, we were at government health centers, but we also visited several traditional healers’ places of practices and talked with patients there.
**Entrée into the Field**

We gained entrée into sites of research through persons in the Department of Community Health at the local Mbarara University of Science and Technology (MUST), which is a public university with a small training hospital in the town of Mbarara, the capital of the district of Mbarara in the Southwest of Uganda (Figure 1). Actual fieldwork was done outside of Mbarara town, in six small, rural villages within a 40 miles radius.

![Figure 2: Uganda and Mbarara District](image)

The relationship with MUST stems from previous years of collaboration with representatives of the MHIRT program, and this association has proven helpful as a way of opening dialogue on possible health studies and health care programs between researchers and students from the US and students and faculty from Uganda. MUST students trained in the Department of Community Health acted as our translators in the
field, and also provided insight for the design of the research by helping to shape the questionnaires. Leaders from this Department introduced us to community leaders, local volunteers, health workers, and healers. They also pointed us to various other organizations in place in Mbarara, and encouraged our pooling resources with them.

Healthy Child Uganda (HCU) is an organization started by the University of Calgary that also has ties with MUST. They allowed us to share our research with them and offered feedback to inform our interviewing process. This small organization carries out some local duties of the Ugandan Ministry of Health. For instance, while we were there they mobilized efforts for a mass immunization program entitled *Child Days*, which goes into rural villages to dispense Vitamin A, de-worming tablets, and measles vaccinations. We accompanied HCU on these trips and talked with parents, mostly mothers, who were bringing their kids in for these preventative medications. These opportunities made for many of our days in the field, and allowed us time with hundreds of participants at schools, clinics, and community centers.

**Research Setting**

Previous research done through this NIH grant in Mbarara focused on doctors and healers, but the phase in which I participated focused on community members and medical consumers.

For most medical consumers and providers, the primary biomedical facilities are government-sponsored health clinics, many of which are either co-sponsored by or associated with foreign aid efforts, volunteer organizations, or health care campaign groups from within Uganda and abroad. The traditional, or *Runyankole* (the primary ethnic group of Mbarara, or more generally, a term for ‘local,’) curing options are more
diverse, and consist mainly of individual operations run from home or small doctors’ offices attached to a home. Traditional birth attendants (TBA’s,) bonesetters, abarangis (fore-tellers,) herbalists, and spiritualists are among the primary specialists who are grouped together generally as omufumus, a term used carefully and with connotations, which will be discussed in following sections.

As a research group, we visited individuals from each of the above practitioner groups in their places of practice- clinics, home offices, community centers, and hospitals. Most often with the accompaniment of translators, we spent days shadowing healers and doctors, sitting in waiting areas to talk with patients, and sitting in for consultations and treatment sessions. With signature or fingerprint permission granted, we first talked with consumers about reasons for visit and then moved into a more general discussion of health, health concerns, and health care experiences. We asked people about previous treatment, expectations for current treatment, and ideas as well as wishes for future treatment.

Mostly, interviews consisted of audio-recorded hour-long sessions on woven fiber mats in fields and yards surrounding clinics and home offices. We asked permission to record and to photograph each participant and gave bottles of soda in exchange for people’s time. We explained that we wanted to use the information provided to build a database of information that contains people’s beliefs as well as their needs. We made it clear that we would never share names or individual’s histories, but that we would quantify the data to report it to the local university, government agencies, and health organizations.
People in Mbarara were more than willing to share. Some people simply needed to vent their troubles or share their stories, others had specific goals in mind for avenues of improvement, but mostly we found that folks self-treat very often, go to biomedical facilities in hopes of getting drugs and instant relief, and see traditional healers for a range of issues, most notably folk diseases (that is, illnesses not recognized by biomedical providers,) and psycho-social disturbances. We did deal with issues of perceived power and had to explain frequently that we could not affect people’s health directly on that day and that we were there to learn and not to provide health services.

**Focus of the Present Piece**

From visits to spaces of healing and from conversations with Mbararans about their health, their bodies, and their experiences in places of health practice, it was obvious that Mbararans (like most people,) explain conditions of illness and visits to treatment places from a personal, experiential, lived perspective. Being in clinics, huts, and home offices made me realize how very different the spheres of treatment can be and how much place impacts experience, and I was struck by the poetic and powerful narratives of affliction and healing. From the group project, I learned basics about illness categories and basic trends in dealing with sickness. From there, I moved my personal research to themes of experience and the lived body and used phenomenological methods to inform the thesis.

I choose to look more closely at how people perceive the conditions of their bodies, what parts of the healing systems represent care and curing, and, specifically, how being in spaces of health care affects experiences of sickness and perceptions of illness in general. To do this, I revisited the health centers and healers and an additional 10 private places of practice. Working off of the basic information I accumulated under
the MHIRT group project, I was able to locate places of health care and ask about specific practices and beliefs, and I had the fortune of being regarded as a researcher rather than a doctor or health care professional. Typically, my side project observations consisted of day-long visits conducted on days off where I mostly watched and recorded. Also, I administered pile sort activities to visitors with images common in health care spaces in order to see what parts of health care services are viewed as important or impactful. In these activities, I simply asked people to select from or place in order a group of 12-13 pictorial representations with prompts asking them about the most effective sources of health care, the most preferable, and that which they use most frequently. From there, conversations sparked on the subject of health and healing. I wanted to see what people view as the actual healing factor and what they seek out in healing spaces. Building on the initial data collected with the MHIRT team, I asked people to describe personal ill conditions in terms of the body in order to understand what part of the sick experience constitutes concern, and I inquired about experiences and procedures in health care venues to see how people describe the health-seeking experience. I chose to study the experiential side of sickness and health and to convey the lived side of medical anthropology in my thesis work, whereas the MHIRT group project relies on quantifiable statistics and coded survey material.

I first saw applications of alternative ethnography, performance, and experiential anthropology as problematic or inappropriate for discussions of health, as it risks making creative capital out of poverty and chronic conditions. The stories and the issues that we encountered seem apt for projects more applied in nature, and which would literally bring medicine to people and elevate systems of care. Then I realized that in order to
adequately describe medicine, bodies, and ill states in Mbarara, we have to understand conditions of experience and the lived body. We have to bring the living perspective into medical discourse and we have to incorporate all notions of self, health, sickness, and cures. For instance, bewitchment and social problems manifest into very serious physical pain and suffering in Uganda, and we must give attention to the practices that cause and cure these situations. I believe that knowledge exists within the active body and that the body is a vehicle for the building of medical discourse and health care infrastructure.

Further research would include questions that ask about spaces of healing more specifically. We found it difficult to elicit self-reflexive notions of experience from stories on needing and seeking care in Uganda as people sometimes normalize their realities and are challenged to express what they know so well. Our research group also found that hypothetical situations do not translate well in Mbarara, so talking about something that is possible, as well as, “What if,” questions are out. Future dialogue and discussions should focus more on attempts to get Mbararans to talk about the self outside of pain descriptions and opinions, and I would like to ask folks to describe space and to diagram places of treatment in a mental map fashion to see explicitly how they conceive of the spaces that I describe herein. In the three-month time period of research allotted by the NIH project, it was impossible for me to get in-depth understandings of all aspects of health care, medical media, and the lived body. More time in the field would have allowed me to establish ample report within these communities and allowed me to conduct research outside of the actual health care facilities. However, due to time constraints, I describe illness and health-seeking from within the treatment spaces, which
I realize presents a certain sway in what people are willing to disclose as well as the depth of conversation achieved in such short stints.

**Medical Pluralism in Mbarara**

In this system with divergent treatment options, there are differences in health-seeking experiences and multiple perspectives on disease itself and its place in the body. It seems that any society could be considered pluralistic medically, but we see a striking partition between knowledge collectives in a place like Uganda, at meeting places of long-standing tradition and growing contact with a globalized health industry. I continue the tradition of medical, anthropological dialogue on the subject of pluralistic healing, and I use the terms *traditional* and *local* in contrast to *biomedical* and *clinical* to designate realms of medicine that are either particular to the area and stemming from a line of thought specific to Southwest Uganda, or that are fairly recently introduced by outsiders or informed by a standardized medical practicum originating in venues of research and applications that do not necessarily relate to the locally available cures or the belief systems of Uganda.

These two realms of health care are not in opposition to one another, nor are they entirely free of influence, but it becomes obvious on the ground that there are very different techniques and materials associated with each of these realms and that the concepts regarding cures in each are distinctive, although the sciences overlap. Moreover, community members in Mbarara conceive of these practices as separate entities and have very specific associations with *Runyankole* (the primary ethnic group of the area, and more generally- ‘local’) and *muzungu* (foreigner). Differences lie in the forms that drugs take in each realm and the associated applications, but mostly in the character of the
spaces, and the experiences of embodiment of the various realms. Charles M. Good refers to traditional healing as, “cumulative…healing arts,” emphasizing the folk nature of these practices, and claims clinical practice, on the other hand, carries the “technological brilliance of scientific biomedicine” (1987: 2,7). Noting the varied approaches to healing is important, because it shows how the same symptoms can be named and catalogued differently based on perspectives and beliefs, and how engagement in particular health care realms influences actual lived experience in addition to ideas and behaviors regarding health and care.

*Realms*, here, refers to actual places of treatment, associated knowledge collectives, and embedded symbols and materials. During my time exploring health and healing in the rural areas of the Mbarara district between May and August of 2009, I found that community members engage both realms of medicine though they find them to be quite distinct. There is a tremendous amount of overlap in the seeking of cures among these realms and there is also a high degree of stirring of symbolic and social facets of each. Mbararans constantly seek care from each realm, and often persons will go back and forth between treatment options to maximize healing care. Though ideas and objects, like the concept of stomach ulcers or packets of headache tablets, are exchanged and carried between medical realms, ideology remains fairly distinct and contained. Biomedical practitioners have what Jean Langford calls an “anatomo-clinical method,” which places disease solely within the body, while local doctors commonly refer to social and metaphysical aspects of health and healing (1995: 331).

Inter-realm care seeking often causes issues as practitioners in each realm provide separate and distinct remedies. There is a complete lack of communication between these
groups of healers. The MHIRT program sustains the long-term goal of supporting cooperation between practitioners because of the high instances of overlapping treatments and the gaps caused in health care when patients go between realms for care. This concept is not new (to the area or to places with similar systems,) but the challenge of multi-realm care and cooperation has yet to be solved in Uganda and calls for much ethnographic engagement.

There comes confusion for health-seeking Mbararans when information gleaned from various treatment places is contradictory, and there is danger for potential over and under-dosing, negation of drugs, or failure to treat when consumers engage multiple realms simultaneously without communication. The most striking portrayal of the disjointed, failing pluralistic system is in the case of cerebral malaria, which is a very common problem, mostly in children. The severe stage of untreated malaria affects the brain and respiration, and results in chills, shaking, and convulsions. The affected mental state of patients with cerebral malaria and the seemingly bizarre behaviors are constantly diagnosed as satanic daemons and bewitchment, which calls for spiritual healing rather than the necessary medication (which is truly not realistic for most due to lack of resources).

The concept of boundaries discussed above comes into play in a discussion of varied realms of care. Lines created between these medical systems are attributed to fundamental differences in the theoretical and cosmological underpinnings of the realms as well as the methodological approaches to the body and remedy possibilities in each. In the stories that follow I describe parts of these systems of care, and demonstrate the radically different attitudes about health and healing within each of these spaces.
Chapter 1: In and through the Spaces of Healing

We look first to the spaces of healing and the particulars of health care facilities in order to gain insight as to what seeking care may be like for Mbararans and to see the intricacies of the curative landscape. Because I cannot visit the affected body, I visit the spaces where bodily applications take place and where there is the most concentrated discussion of ill health and afflicted conditions. I personally spent the majority of my time in Uganda in these spaces, so I feel that a description of places of healing is a description of my Mbarara.

Understanding the experiences of being sick, the conditions of perplexing bodily states, and the challenges to seeking care in Mbarara becomes easier when we understand the spaces where illness leads, where sickness is the common theme, and where wellness is the goal. There is no doubt that the experience of illness or health is in the biological body, but I suggest that the experience of space is also in the body. I also argue that experience is the core of a study on medicine and healing, and I believe that expressions of self and of health are a clear way of accounting for the experience of bodily states.

Therefore, conversation and analyses of the material world guide and inform the present ethnography. I attempt to transcend the personal experiences of sickness and wellness by interpreting expressions voiced by community members (in Chapter 3,) as well as that which is embedded in the landscape of health facilities in Mbarara.

Machines and Mirrors

At 9:00 on a Tuesday morning, the Level 4 Health Center in Kinoni, a central village along a main road in the district of Mbarara, is crawling. The clinician never came yesterday, so those who ventured to the center the day before are back. Those who
admitted themselves over the weekend have clothes hanging out to dry, receive tea in
canteens from teenaged girls, and lie on cots with the same expressions that they had on
Saturday: raised eyebrows of anticipation and worry. Children in smartly pressed school
uniforms sleep in the sun on the backside of one of three utilized standard concrete block
buildings at the clinic; one girl has a rash on her leg which worries her and for which she
walked two kilometers in the opposite direction than normal this morning. This main
building has “Outpatient” painted on the entrance to a deep portico (Figure 3) which
serves as an area for those waiting to see the one health worker who, at 10:00am is two
hours late and who arrives eventually around 11:00 by motorcycle with a slight red tinge
to his white lab coat dusted by the dried earth which has settled on every surface in
Mbarara during this rain-less month of June.

Figure 3: Health Center 4- Outpatient Ward.

On left in photo is new construction that will expand the space of the ward. On
far right in photo is the latrine provided for the clinic as well as near-by families
and businesses.

Blue rubber boots smack that dusty earthen path and squeak up the three smooth
concrete steps to the adjacent, facing building. The sound of these boots and the gentle
smile that follows is familiar to the patients in this ward. It is the “General Ward,” but it
is understood that these people are facing serious problems, and those boots and that
smile are all that they have seen in the way of care in days of waiting. The boots belong
to Henry, the “support staff,” as he’s called. He unlocks doors; he shifts files; he makes the lines move; he keeps this place running.

This HC (Health Center) is ranked level 4 out of 4 because it is the most equipped of the government-sponsored facilities in the area and offers more services than the
typical HC2, which can only dispense basic, if available, medicine and has no diagnostic capabilities. The HC4 is one step down from the district hospital. People come here because there may actually be medicine. Also, there are a lot of trucks that come from Mbarara town, the district capital and the site of a small training hospital, and consequently also coming in are doctors, volunteers, and some local and foreign supervision and resources.

**Policy and Recent History**

Supervisory and assessment-based attention make up most of the consideration that the health centers receive as a result of Uganda’s past filled with corruption and bizarre and cruel politics, but also as a result of the fact that there is little else for government and aid-based groups to do without radical changes in health procedures and drug distribution. Adome, Whyte and Hardon (1996) report that the 1960’s were times of stability and solid management for health services in Uganda, but the 1971 Idi Amin takeover introduced destruction, fleeing health workers, and abandoned facilities. The National Resistant Movement restored some sense of control in 1986 with a drug supply campaign, but the country has still not recovered. “There is a grave lack of trained staff particularly in rural areas,” say the authors, and usually communities attempt to fill in for inadequate workers with minimally trained volunteers (Adome, Whyte, and Hardon 1996: 10).

After decades of teeter-tottering control of infrastructure such as this health center, decentralized, district-run facilities belong to and are managed by the local branches of the Ministry of Health and policy is affected by these branches as well as by
various NGO’s (Kisubi 1999). One such NGO is the University of Calgary-born HCU (Healthy Child Uganda,) with which my team and I were affiliated via contact with the Mbarara University of Science and Technology (MUST), which is the training institution associated with the regional hospital. The HC4 sees much more attention and inspection than the HC2, and the presence of outsiders and foreign health programs give this space connotations of Western care, though the reality on this day is an empty treatment room and a yard full of potential patients.

The groups of mothers resting on sheets of fabric unwound from around their waists and placed as mats on the grass; the children passing a bottle of cough syrup that one family brought from home; and an ancient-looking man, slowly making it up the hill and passed the bicycle repair station marked by a circle of oil-drenched soil to rest his arthritic body on the portico steps, are parts of a typical scene at the health centers, where waiting and interacting are part of the experience.

![Mother at the Health Center](image)

Fig 5: Mother at the Health Center

An experienced mother of 5 talks to a young girl about her children's cough outside of the Health Center.

The shawl the woman wears has been her resting place for the majority of the morning while she waited for the health worker to arrive.
Young mothers share baby-burden stories and the older tell the younger how it is done. The girl with the leg rash is advised by a woman, who I later came to know as an herbalist, to get a cream made by a local *mzee* (elder, wise man) and to stop wasting her time at the clinic. The herbalist was there for pain medicine; she suffers from sore joints, she tells me, from her constant grinding and pounding and mixing of herbal treatments. Others watch the exchange and some kids laugh at the girl when she shushes the woman. The atmosphere of care at the HC4 is extremely public; there are no private consultations as the space designated for outpatient sessions is also a thoroughfare for support staff and is behind a cracked door with ears pressed against the other side. While waiting, conversing about reasons for visiting is the norm.

Once the families, individuals, and pairs make it into the portico upon arrival of the clinician, they receive numbers, and shift along peripheral wall benches around a table sometimes used for groups who utilize the waiting time in the mornings to give lectures, hand out condoms, and to emphasize the messages already surrounding us, in posters on the walls, often in English, about the duties of a healthy citizen (fig. 6). These posters cover the walls of nearly every public health venue. They are, like many efforts for health care improvement in Uganda, a show; they are stamps in the spaces that mark some presence of government aid and improvement objectives, but have no meat and no action backing them. They serve as the guestbook for foreign groups and national powerfuls.

The Ministry of Health icon, and logos of various volunteer programs and NGO’s, adorn the bottom edges of the aged paper campaigns printed with minimal funds that did not go toward drugs or infrastructure. The posters serve as colorful ways of facading care
and cures where actual treatment is not a reality. The posters are the material corpses of fleeting campaigns from the last 20 years focused on education and prevention-care campaigns that continually are the only feasible effort in areas far removed from radical change.

A swinging door leads from the concrete portico to a small room (fig. 7) with a desk and two chairs, where the clinician leads very brief treatment sessions which consist of disclosure of symptoms and presentation of a record notebook required by all visitors to any clinic. The notebooks are the same blue folded paper stacks that schoolchildren keep, and they show a sense of standardization, regime, sanction, and formality that is the objective of the British-implemented, English-based school system.

Fig 6: Posters Showcasing Campaign Slogans and Emblems

Clockwise from top left: Sida (Swedish International Development Agency) along with Kampala’s Makerere University’s hygiene-based posters; The Ministry of Health’s Reproductive Health Division emphasizes pregnancy screenings; Campaign to fight STD’s from USAID (United States Agency for International Development) and the Ugandan government. The rainbow/flower sign has become a universal symbol in the country that represents available “Family Planning” (birth control) and STD services at health facilities; Uganda Water and Sanitation NGO Network (UWASNET) emblem from an ad that calls for clean water free of defecation.
The consultation space is the common area in a room that leads to several other smaller rooms and a back exit. The separate rooms are the “Dispensary” and the “Injection Room,” (see Figure 4) the doors to which stay closed but give the room a feeling of potential openness and create closed off but present extensions of space.

Sometimes with no words and normally with no physical exam, the clinician writes a drug name or recommendation in the blue books, then the patient exits the typically 2-5 minute sitting. She goes outside and around to the side of the outpatient ward and through a window in the building receives medication from a community member or support staff who is tucked into the small Dispensary room that houses a wooden cabinet with a masters lock and several paper boxes of drugs (fig 7). Drugs dispensed at any government HC are supposed to be free, but usually supplies are limited to a handful of basic bacterial creams, acetyaminophenols, and cough syrups.
The third operational building in the compound is the maternity ward. One woman, Rose, runs this ward, where she tells me that she can give advice, check-ups, and occasionally deliver babies; she prefers to refer mothers to the hospital for delivery. However, many women choose or are forced to deliver at home or at the residence of a Traditional Birth Attendant (TBA) because Rose comes three days a week and leaves around 4:00pm. The hospital is a very bumpy 40-minute car ride away, or a motorcycle ride that no one can take because of cost and absence from home.

Fig. 8: Maternity Ward Spaces

Left, view from the entrance of the maternity ward.
Right, looking into maternity hallway from the room on the far right in left photo.

Rose has access to three beds, gauze, latex gloves, a scale, plastic bins, a stack of forms providing spaces for three pregnancy screenings, needles and occasional tetanus vaccinations, razor blades, and a crib. More than anything, Rose emphasizes her role as an educator. She is seeing a woman on this day who she gives the practiced lecture on both-partner prevention, an unofficial campaign geared toward opening communication
between married couples on the subject of faithfulness and HIV prevention. This “sensitization” effort is among many that health workers in Uganda claim is their primary job or sometimes only way of providing care in venues where medication and equipment are extremely limited.

The fourth and fifth buildings in this health care compound are the theatre (surgery) ward and the lab, neither of which are operational. Labs are loosely understood as places where blood and urine samples as well as modern medicines are tested, which in the rural areas are limited to privately owned diagnostic centers in near-by city centers where HIV and other STD’s are tested, but mostly malarial infections are identified.

Malaria, the region’s foremost severe illness and prominent killer, is well understood and its symptoms known, therefore those without access to extra funds self-diagnose and self-medicate without the aid of lab testing.

“Machines,” Labs, and Diagnoses

Diagnoses are not a typical part of health treatment in Uganda. Patients often take drugs administered without a statement of diagnosis and are well suited to self-diagnose in
cases of malaria and other common health problems, such as pneumonia, intestinal worms, and skin infections; at least, this is the general assumption. Other symptoms and general dis-ease, such as fatigue, headache, and soreness remain clouded in mystery or are ignored or understood as a result of over-work or poor diet and hygiene. Ugandans recognize the fact that the lack of diagnostics and proper testing accounts for much of their falling victim to mistreatment and improper administration of drugs. They call for “machines” in the clinics and trust the computer-generated lab results found at diagnostic centers. Panadol, an acetylaminophenol pain reliever and fever reducer manufactured by GlaxoSmithKline, is an extremely common medication given in times of indeterminate illness and as filler in times of lacking medications.

The Mother’s Burden

In Uganda, where faulty water and waste infrastructure account for much of the spread of contagious disease, official health programs and government health operations target home prevention and self-sustained sanitation, placing the burden of health maintenance on those who feed and clean an immediate family, usually mothers.

Common slogans and poster-culture highlight cleanliness, faithfulness, and regular check-ups, all of which do nothing for mosquito populations, lack of immunizations, inaccessible medical supplies, deteriorating latrines, contaminated water, or corrupt officials. Hygienic practices are commonly discussed in health venues and often cited by consumers and providers alike as the cause of ill health, perhaps due to the emphasis on waste management by outsiders and perhaps leading to taboo associations with feces, a material imparted with negativity and the power to bewitch. Failure to uphold the standards of home prevention techniques tends to be associated with the same
shame that is attached to seeking care from dishonorable practitioners. Many mission-based organizations, foreign volunteer efforts, government-facilitated reach-out programs, and radical Christian groups discourage the use of traditional doctors and herbal medications, affecting practices of self-care which typically involve botanicals and household items.

Fig 10: Posters from HC2 and HC4 Highlighting Mothers' Duties

Clockwise from top left: promoting mosquito net use for malaria prevention, breastfeeding for malnutrition prevention, and latrine use for home hygiene – all preventative strategies that focus on the role of the mother
Those Who Work with Both Hands

A strong stigma is associated with the seeking of care from local doctors, partially due to the influence of outside groups and partially due to negative experiences with those who work with ancestral, spiritual, and social powers, which have proven to fail to cure or are identified as the source of pain and sickness. Though many seek out local doctors and fore-tellers to undo curses, Mbararans acknowledge that these practitioners, “work on both sides,” or “with both hands,” meaning that they are capable of evil as well as healing and can be the cause of one’s problematic conditions.

Community members complain that these healers are often tricking people; they inflict a curse so that folks are forced to come pay a high fee to have the curse taken off. The highest form of witchcraft in the area comes from witches who, “work in the night,” to take and kill pure, innocent children. Commonly in print media and radio broadcasts, there are reports of child abduction at the hands of a certain group of omufumus (general term for local healer but with negative connotations,) who steal and sacrifice children to strengthen their own spiritual bond and increase their power.

Fig. 11: Traditional Healers Poster

Poster published by a local, traditional healers’ organization that, after persuasion from the Ministry of Health, has turned its focus away from training local doctors and onto promoting referrals to a local hospital or clinic.

The images show local doctors’ practices with: crowded spaces full of sick people; a doctor cutting into a patient’s skin, delivering a baby amidst dirty cloth and walls, spitting into a drug mixture, and having sex with a patient. There is a belief that healers persuade or force sex on women who seek care for infertility.

I took this photo at the home of a practiced healer who prides himself on his authenticity and the standards of care that he upholds. He believes that these illegitimate acts occur and feels strongly about preventing them.
Although traditional medicine is frequently shrouded with secrecy and denial, this is not the case for all factions of local care, which is proven to be the primary health care for most people in the area. The role of the traditional birth attendant (TBA) is clear and well-appreciated; herbalists operate day in and day out to varying degrees of effectiveness and sincerity; bone-setters are held in very high regard due to the emergency situations in which they operate and because broken and fractured bones are obvious and need immediate attention; spiritual healers, however, are widely regarded with fear and distrust.

Diviners, spiritual healers, and magic-conjurers are a diverse group, ranging from those who work with herbal and material talismans meant to protect and heal to those who exercise daemons and spirits, to those who can visualize sickness and answer the questions that the machine-lacking HC facilities leave unanswered. Often, abaranjis (foretellers) are the diagnostic center for those who feel down on their luck, incessantly sick, or who need guidance, treatment, or information unobtainable in everyday life or through the menial biomedical system of psychological and physical care. “The site explicitly devoted to conversing about suffering is the diviners’ hut,” and these practitioners welcome perplexing problems and deal in the unknown (Whyte 1997:16).

**Fires and Horns and Other “Strange Things”**: The Diviner’s Hut

Richard, a young man who has purchased a 4-door sedan with borrowed money and collected family funds, drove me to the house of a known “witchdoctor,” as Richard calls him, early on a sunny morning in July. Richard is glad to have been hired for the entire day, but really wishes it were not with someone seeking information from such a person.

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3 Quoted from a later interview with a 30-year old woman describing the medical material used by diviners and fore-seers.
He stops a distance away from the house and hangs a peach-scented image of a cross from the rearview mirror. My translator accompanied me this day and she jokes with Richard about walking fearlessly into the space of a witch; she tells him that my white face will protect her. We walked passed the doctor’s sign, — “Dr. Kwetegyereza / Omushaho wekiragjuu,” (Dr. Kwetegyereza/ Traditional Doctor) — and through his well-kept yard occupied by a tame dog, healthy goats, and newborn chicks.

Directly inside the iron door covered by a tattered curtain there was a room full of bulky carved wooden benches, smaller wooden chairs, a large wooden table and at the far end of the room, a doorway to the courtyard covered by a similarly tattered but much larger curtain. A woman sat inside having a typical Ugandan breakfast: toast with “mixed fruit” preserves and black tea. She looked away from me as intensely as possible as if to dismiss me or deny my being there. A young man sat sipping slowly a dark herbal tincture with leafy bits floating around a reused bottle, which once held a locally manufactured sweet, port-like V&A™ wine. He is dressed for work and quickly takes off when the bottle is emptied. In glides the doctor in a button-up collared shirt made from the prevalent wax-dyed fabric, slacks, and leather sandals. Most men dress this way in Mbarara, but his shirt is longer than others’ and has big square pockets at the bottom like a lab coat. He was expecting me so my being there was no surprise. He ignored me and called to the quiet woman; they left together through the courtyard door.

A minute later a 10-year old boy, the doctor’s son and one gifted with the same abilities to see the spirits as his father, came bouncing in to ask me why I did not follow his father and the lady to the consultation space; I answered that I did not know if he was
ready for me or if the woman was willing to have me sit in. The child smiled his very handsome, big-toothed smile and told me to go next time.
The doctor’s first patient was gone for over an hour. In the meantime, an older woman with a cane and a crescent moon-shaped back stuck her head in the entrance curtain and promptly back out, and a teenaged housegirl\(^4\) came to stare at me and stroke my hair for a minute before returning to mashing *matoke*, a starchy banana plant (more starchy than plantain and much less sweet than common yellow banana) and main food staple. Soon, another woman in her 40’s came in and sat briefly before she, my translator, and I were called to the treatment areas behind the courtyard, passed an adjacent building under construction (fig 12). I never saw the first lady leave, but the housegirl cleaned up the remains of the toast and tea.

After gaining permission to sit in on the second woman’s consultation, we all entered the second of two thatch huts (fig 14) made of woven dried *matoke* leaves and with walls of stick and mud packed-earth\(^5\) situated inside of a tall fence-like wall of vines

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\(^4\) This is what Ugandans call girls who work with household chores. These are usually very young girls or teenagers who are paid minimally or with food and shelter. Some are orphans, but more often they are neighbors who do not yet have children.

\(^5\) The house construction method most common in the villages
and chili pepper plants. The viney wall marked off the huts’ area within the expansive field of shady matoke trees, which I had learned was the coverings for dozens of medicinal plants during a tour of the doctor’s home with the MHIRT research team two days prior. The huts stood in contrast to the other metal, brick, and concrete structures in the compound. The doctor told me later that he practices a traditional form of medicine, and that the spirits, which activate and inform his remedies are attracted to and insist upon traditional materials native to Africa. “This is African medicine, not like what you whites practice in your country. These are African materials; from this soil and that the spirits know. [The spirits] can’t come in through metal sheet roofs.”

A similar response was provided when I asked about the doctor’s choices in decoration and medicinal media. We sat on layers of wax-dyed fabrics in the hut for the woman’s two hour session while the doctor sat before a worn animal skin (fig. 14). A tiny fire burning in a hole in the earth was kept shielded by three small stones and divided doctor and patient. He had a notebook in which he wrote often and to which he referred
for information regarding the woman’s previous visit as he lit a small pipe and blew his puffs of smoke into a shard of a broken mirror propped on a rock and leaning on the wall of the hut. Franceen (the consumer’s pseudonym) poured her troubles into the drafty hut like an uncorked fountain.

The doctor grasped a handful of beads, coins, shells, and seeds and shook and tossed them like dice on the animal skin as he asked the woman about her ailments. She began by describing fits of dizziness. He threw the seeds and beads and looked piercingly into the mirror while she talked. The configuration in which the items landed on the third toss was clearly in keeping with the doctor’s hypothesis as he nodded and quickly sought additional information. He plucked one seed from the pile and dropped it in a glass of special river water. With the eraser end of his No.2 pencil, he poked the floating seed and again while it rose. I assumed the pattern and speed of the rising seed was indicative of the reality of some parallel situation that he was thinking about, but I was not there to learn the intricacies of divination, so I watched the drama and the response to see Franceen’s expression turn curious and attentive. The doctor said nothing, but nodded and smoked, tossed and listened.

One round bead rolled away from him on the sixth throw and he looked at her with wide eyes. Quickly, he jumped up, slipped on the sandals that had been removed before entering, and went to the other hut, which was revealed to me later to be the treatment space for demonic and satanic illnesses, out of which whistle and horn soundings came that summoned additional spirit powers. The mood was tense and the patient seemed entrenched. Dr. K returned quickly and brought a gourd with a murky, white matoke fermentation. From the straw he pulled hard to get a mouthful, which he
spat at the mirror. The conversation turned from symptom narrative to exploration of spiritual sickness. Franceen revealed to him that she believed that she was bewitched. He nodded as if he knew. She disclosed information about her marital break-up and her disputes with her neighbors. With much further probing from the doctor, Franceen revealed that the neighbor’s son had hidden “drugs” on her property, which he told her was the cause of her inability to “organize her life.” She had been bewitched, had negative emotion placed on her, and was suffering from evil that was making her physically sick.

At the arrival of the source of infliction, the tension broke. A sense of relief and release came over the two people who had been involved in a nervous exchange for hours. Franceen sat back and ungripped her fingers; the doctor slouched a bit, and the two exchanged small talk and humor.

The doctor incessantly suggested that her troubles lie in the fact that she had not organized her home or prepared her dwelling space for the spirits to come in. His tone was disciplinary and his prescription was for a high-priced bundle of herbs, a charm, which he would make and bless with the spirits of the ancestors and that she could use to protect herself and to reverse bewitchment back onto the bewitcher. He asked for 200,000 Ugandan shillings for this treatment, which is roughly $100. (For comparison, two weeks worth of two different medications for a viral infection cost 3,000 shillings at a pharmacy, which is entirely out of the question for most people. 200,000 shillings is more than many see in a lifetime.) Franceen attempted bargaining, but the doctor held solid on

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6 Bewitching charms; bundles of herbs made by omufumus, which are placed where people cannot see them but will be in proximity or interaction with the body. For instance, under a bed or under the steps where the body will cross over, whereby the bad spirits enter the body and the person becomes afflicted with bad luck and illness, which are considered to go hand in hand.
the price; he offered an installment plan. She could not make the payment, so she paid the 500-shilling consultation fee and was on her way, but not before he offered her free advice for organizing her home and thusly her life.

**Concepts of Home**

An organized home is a home that is swept and tidy, but more importantly is kept up with proper doorway coverings and food preparation items says Alice, a key consultant I would meet later in the summer who told me that houses are a primary protection against illness. Apollo, another key consultant with whom I met several times to discuss the condition of public health and his sick eldest child, told me that just as illness comes from within the body, health comes from within the home. Spaces, or “environments,” must be kept clean and organized, just as one must organize his life by working hard and keeping the family together.

Dr. Kwetegyereza believes that spaces must be cleared within the home and items placed in a straight and inward-facing direction in order to allow spirits to come in and bless the people within. Objects within the home are symbols of realities outside of the home that are out of one’s control. Ceremonies performed by abarangis (foretellers) and other spirit healers are usually done in the home or compound of the afflicted since spirits and ghosts that haunt come into bodies through entering the home or through materials within the homesite. An analysis of parallels between home and body is in order, but that is a separate thesis.

Local doctors typically have multi-use of the intimate and self-reflective spaces that are their homes. Every Ryankore healer that I visited used his or her house as the

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7 Alice may be referring to keeping mosquitoes and flies as well as night air and dust out of the eating and sleeping areas. All four of these environmental elements are directly associated with sickness and bodily discomfort.
space in which to heal, so visitors engage the complex, intimate space of home when seeking care from a local practitioner. Dr. K’s healing space is planned in such a way that the further into his property one moves, the more involved the treatment becomes.

Bernard, a mzee (elder; wise man) who has been in the practice of herbal medicine for 50 years, has a similar setup although his treatment style differs considerably. Bernard is a dignified and well-respected herbal doctor who specializes in curing so-called terminal illnesses. He is said to reverse diagnoses of HIV and cancer and he, unlike Dr. K, insists on physical examinations. His curing space is in his home from which he distributes several readily-prepared herbal medicines that he sells steadily, in addition to seeing an average of two additional patients per day.

**Soothing Honey and a Courtyard Waltz**

I was introduced to Bernard through a friend and THETA (Traditional and modern Health practitioners Together against AIDS and other diseases) member. Bernard’s place of practice is absent of all colorful paint, but in its place are vivid and aromatic flowers and herbs, which dangle from homemade trellises and pop up in plastic bin-pots around a large tree that makes glimmers of light through its leaves. Bernard’s wife, daughter, and housegirl waltz through the courtyard and out to the beehives and back again with handfuls of potent stems, barks, and roots. They are making a stomach-settling drug and add honey for taste and for its soothing benefits.

The air at Bernard’s home feels crisp, free of dust- a rarity this time of year.

Bernard is old but spry, and concerted. Sessions with Bernard last several hours and he insists on follow-up exams, even for the simplest cold. His slow, calm voice and steady,
wrinkled hands put me at ease as he explains his philosophies of the body and of medicine. I shed the tension of the morning at the clinic and become comfortable.

Bernard has a sitting area where he asks people to describe symptoms and where he holds discussions (fig. 15). A kitchen area is directly behind that (through the curtain in the picture) where he has burners and huge pots of boiling herbal waters that he pours into reused water bottles of which there are stacks. Through another doorway from the measuring and bottling area, there is a room with a bed that is the exam area for cases that require physical and private assessment. Often, he says, “women’s issues” are the more severe cases, quoting childbirth complications, placenta removal, and HIV.

Bernard’s space parallels the clinical spaces discussed above in that succession through the facilities begins customary and becomes more intense and more invasive. Procession through the compound of the HC4 reveals the maternity ward at the back of the property and the outpatient ward at the front. Patients with more complex and lengthy
visits will be further embedded in the treatment spaces. In this way, the spaces of healing directly coordinate with the body; the more severe the condition within the body, the more embedded in the sphere of illness a medical consumer is, and the more entrenched in the spaces of healing she becomes.

In the Body, Out of Illness

One will absorb botanical smells, glimmers of light, careful touch, and serene, organized space in Bernard’s home practice, but for all that goes into the body at this healers’ home, there must also be material that comes out. Bernard insists that in order to cure illness or for the body to properly take in curative medicine, there must be a ridding of infected or discomfort-causing matter. He takes several approaches to forcing ill matter from the body, including causing vomiting, diarrhea, sneezing, and bleeding. He tells me that there are avenues for disease and that medicines should target directly those avenues that hold or correspond with sickened or dysfunctioning parts.

Many of his examples seem intuitive: for “rumbling” (upset) stomach, he concludes that something which was ingested needs to come out, so he recommends diarrhea prompted by his herbal waters or enemas. Headache, says Bernard, is caused by accumulation of environmental factors (like dust) in the head, which enter through the nose, so he uses the same avenue for the materials’ exit. The herbalist dries and grinds peppery herbs that he then has patients sniff small amounts of throughout the day, so that they will release the particles which they have breathed in and release head tension or pain.

Bernard, along with other local practitioners, treats what Mbararans refer to as “folk diseases,” which are identified as coming out of traditional beliefs and are
unrecognized by biomedical providers. A popular practice in folk healing is *akushundaga* (a general term for scoring the skin with small razor blades) to release “waters” from swelling, “bad,” or infected blood, or to remove illness-causing items and pathogens. These applied, hands-on techniques seem to form a bond or relationship between healer and consumer, and provide an instance where medical treatment is based on extraction and getting material *out* of the body. I discuss *akushundaga* in detail later in the thesis.

The clear and comforting spaces in which Bernard applies his medical theory are parts of his self-contained health compound, though he sees it simply as his home. The herbs, roots, stems, barks, honeys, and waters that Bernard uses for his practice are all taken directly from his house, his yard, or near-by fields. He has a small garden directly outside his consultation space that he says holds the simple stuff. These are plants that grow fast and that he uses a lot, like aloe vera. There is a larger garden plot directly outside of his yard area, where he plants herbs that require more drainage and of which he requires large amounts in order to use properly. This plot also contains some of his simple curative plants, because he likes to share them with others who live near-by. Bernard offers a communal garden area which he promotes among fellow community members, but he holds that it is his long-term experience in detecting, identifying, and treating illness that makes it necessary for others to go past the gratis herbs and into his office.

Most Mbararans are familiar with dozens of varieties of herbs, many of which grow wild and are available in near-by woods, and most people view herbs as an everyday presence. However, other than a few very basic remedies for conditions like intestinal worms and cough, herbs require the expertise of herbalists for preparation and
administration, especially for less common ailments and injuries. Most people in rural Mbarara perform intense physical activity for most of the hours of the day, so pre-made herbal treatments are helpful and convenient when boiling, grinding, and pressing the plants is just not possible due to exhaustion.

**Healing Processions and Desperate Times**

Bernard’s compound is tucked behind small, impassible roads and down thick earthen paths, which create a sense of security, privacy, and coziness at his home. The entrance to his consultation space is an open doorway, and his place is spacious and relaxing. The majority of the time spent in a consultation with Bernard is dedicated to description of illness and recounting of symptoms. Most local doctors admit that listening to a patient talk, maybe about the health issue at hand and maybe not, is a large part of their job.

Procession through Bernard’s home begins with personal engagement and usually moves into his open garden or yard. His tucked away spaces are in great contrast to the health clinics, which are usually on higher ground and in a spot obvious from a main thoroughfare. Approach to the health centers are wide and public, eventually zooming into a cramped consultation space where the most deliberate performance of giving and receiving care takes place.

There is what I call a “funnel affect” in operation at the rural clinics. High numbers of potential patients (>20 at HC2; >50 at HC4) on a typical day will wait or compete for the attention of usually one or two health care workers who are sometimes only there for a few hours of the day. There is a certain sense of urgency to be seen, and a feeling of desperation from consumers whose health and that of their family is at hand. Pearl Katz found, among everyday spaces in Taos culture, that crowded places can
instigate patterns of “aggressiveness, hostility, [and] suspicion” (1974: 300). This is very much the case in Mbarara during times of drug delivery and days of mass distribution (fig 16). Limited resources set off frenzies of activity and spark wild suspicions as community members rush to receive drugs that will quickly be dispersed.

Fig 16: Child Day at the Health Center 2

On a government-sponsored “Child Day,” mothers and siblings line up to get the remaining medications for children under 5 years of age. This particular effort provides measles vaccinations, de-worming tablets, and Vitamin A dosages, and supplies are limited.

In the past, drugs have disappeared immediately, pockets of health workers have fattened as a result with no treatment provided, but with increased community and government supervision, health workers are forced to comply.⁸ That said, the reputation remains and health workers are closely watched and scrutinized, as are their friends and family. During these spurts of attention from afar, the spaces become bombarded and care becomes gridlocked.

⁸ There are rampant accounts of health workers stealing drugs delivered by the Ministry of Health, and selling them to private clinics or pharmacies. Adome, Whyte, and Hardon report this abuse of power as many do: an attempt on the part of workers to compensate for low to no pay. They write, “Many of the doctors who do remain in Government service have one leg in the hospital and the other in private practice in order to ‘make ends meet.’” (1996:10).
Furthering the portrayal of the clinics as spaces of friction and indignity, some consumers experience a certain level of embarrassment while seeking care as a result of a lack of privacy coupled with health workers’ penalizing attitudes. Helen Regis notes a similar sense of embarrassment among Fulbe persons whose “precarious” position becomes public at times of acknowledged illness (2003: 35). The intimidating tone of the clinics make the spaces of treatment constricted, tense, and sometimes dreadful. Various agencies of health care in Mbarara have noticed the daunting quality of the clinics, and in response most clinics are adorned with colorful cartoons and bright Disney™ themes, which have become a recognizable face for almost every clinic in the district. The standardized plan of the rectangular concrete block buildings, with bright colors and jolly characters, stands out against the red soil, brown houses, and green banana trees that dominate the rest of the Mbararan scene.

**Practitioner/ Patient Relationship**

Some members of villages who are not fortunate enough to have someone like Bernard to treat them complain that herbalists are corrupt and opportunistic money-makers who take advantage of their access to guarded recipes or who have a tight grip on medicines for which they overcharge patients. One herbalist accused of this capitalist strategy pointed out that it is just a job for him, and that he has to make money “as any shopkeeper or farmer” must do. He asks this question: “Just because we are working with the local drugs, you expect it to be volunteer? Would you ask the pharmacy for free drugs?” This practitioner touches on an interesting point; herbs and local cures are viewed as close-to-home, household, everyday, communal, and as one woman describes, “coming out of the same soil that we dig in, that we cultivate, where we live and our babies are
born…[where] our rains fall.” In the same vein, local healers are neighbors, friends, mothers, and familiar faces to the ones that they treat, so relationships become entangled with business. This is true of the biomedical spectrum as well. Health workers in rural clinics often work in close proximity to home, though there are many who commute short distances as well.

Relationships between health workers and community members are steeped in power dynamics, especially in larger venues like the HC4. Health workers have access to potentially life-changing medications and supplies that typically quickly dissipate and only reach a tiny fraction of the population. Workers also have access to automobiles that come from the district capital or that are government issued personal-use vehicles. Means of transportation and connections to government-issued supplies put health workers on a level above others who are at the mercy of their favoritism or bribes.

It is widely speculated and often proven that some clinicians use their power to their own advantage to gain resources either from the community, in the form of food or land, or from the public health side, like selling the drugs to private venues to make up for the less than adequate salaries (Adome, Whyte, and Hardon 1996: 10). More ephemerally, though, these power plays produce hierarchies and create structures of communication within spaces of treatment, which stunt personal agency and limit the effectiveness of the health care exchange. From conversations with Mbararans and through observation of health care consultations, my group learned that there is a certain amount of mistreatment and verbal abuse in spaces of treatment, predominantly in clinics and the biomedical setting.
It has been revealed to me that health care consumers often feel punishable and disciplined, or vulnerable and powerless in rural clinics where workers are underpaid, overworked, and often frustrated. Percy, a shy young mother, took her child first to an herbalist for fever and vomiting several months prior to speaking with me. When that practitioner’s treatment failed, she brought him to an HC2, where the health worker has a personal aversion to traditional forms of medicine. Percy was scrutinized for her participation in the shamed local practices and was refused service.

Another biomedical consumer, Faith, along with many others, told me that she feels insulted sometimes when she visits the clinic. Faith describes the medical exchange as constrained. She says that sometimes she may have an opinion about what the health problem may be, but that she is not be able to share her ideas because the clinicians do not want to be told how to provide care. The punitive and disciplinary tone of the clinics is mirrored in some of the material culture. Posters and health campaigns that emphasize prevention and self-motivated home care convey a sense of dishonor associated with failure to prevent illnesses (fig 17). Many of the slogans and images also seem to portray health or cures as easily attainable, making the afflicted conditions inexcusable.

Consumers’ interactions with these messages and health providers reflect an environment of fear and shame in response to demands of subscription to certain life practices, and I believe that the environment of the clinics is one that encourages pro-action on the surface, but does not allow or lend itself to such individual control over health and illness, though it does put illness in the hands of the people and emphasize the body over society.
Jean Langford argues that biomedicine places illness in specific points of the body (1995: 331). I agree that clinical medicine is based on pragmatic and corporeal approaches to the body, but I see clinics in Mbarara as spaces that prompt consumers to look far beyond their own physical bodies, and often to rely on the powers of technology and “modern” medicines coming from afar. We were told over and over that consumers overtly trust medicine coming out of Europe or America because there is a standard of medical practice and production. Overall, people in Mbarara assume that Western medicine is tested and that people practicing biomedicine are well trained.

The biomedical domain is a global connection to widespread foreign aid and institutional, government campaigns, whereas the traditional health system is

Fig 17: Shame-Inducing Posters

Left, The Reproductive Health Division of the Ministry of Health asks parents to “space children,” which ultimately means to have fewer and divvy resources.

Right, The Fight Malaria campaign calls for parents to act immediately if they suspect malaria to avoid advanced stages.
fundamentally familiar and local and is associated with notions of home. In the following section, I analyze what this means and how people make decisions about health care based on illness constructions and belief systems as well as the nature of the places of treatment.
Chapter 2: Navigating Medical Realities

Spatial configurations may both organize a culture and be organized by it. - Pearl Katz, influenced by Edward T. Hall (1974:301)

Spaces of medical treatment and healing are internalized and influential, and by engaging in places of practice and forms of curing, people absorb and interpret, and thusly generate and shape treatment spaces. Sites of health care in Mbarara are varied, but compose a whole system in which community members choose, move, and reciprocate body-space dynamics. If we envision the diverse and distinct treatment realms in Mbarara as a collective system in which community members decide, act, and construct, then we can also see a building and responding material landscape, which is a manifestation of the perceptions and behaviors of those within. Humans make place by active and engaged being-in, but spaces also affect us. Spaces communicate to consumers, and spaces respond as consumers take from and add to those spaces with which they connect.

Conceptualizing the Medical Landscape

Byron Good explains the encompassing field of perception and understanding as a “lifeworld,” that Csordas writes is made up of, “material arrangements of social space,” (Good 1994: 122; Csordas 1990: 2). Those material arrangements are expressions that form through human organization and practice. The notion of landscape, inspired by traditions in geography\(^9\), is particularly useful in imagining an integrated scene in which actors take in space and contribute to an array of materials and ideas. James Potter, inspired by Chris Tilley’s work on phenomenology and landscape, writes:

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\(^9\) I refer the reader to Fred B. Kniffen's *Material Culture in the Geographic Interpretation of the Landscape* (1974), which presents the notion that geographers are tied to the landscape's material forms and to the interplay between surroundings and culture (pg 252-253).
Landscapes are continually in a process of creation by human activity... ‘The landscape is an anonymous sculptural form always already fashioned by human agency, never completed, and constantly being added to,’ (2004: 322).

Through engagement in the collective spaces of healing, consumers build the landscape and create *place*, by defining and categorizing experiences and surroundings. The medical landscape of Mbarara includes practices and understandings, such as illness explanations and cure-seeking behaviors, as well as material culture, such as buildings and instruments.

The collective system of health care is part of what Susan J. Rasmussen calls a “landscape of knowledge... with its own paths, crossroads, and barriers” (2000: 245). Through choices in health treatments and participation in curative spaces, consumers move through, or *navigate*, and therefore make patterns in the landscape. These patterns are products of interaction and form through knowledge sharing, such as advice on curing methods, and by practices such as visits to one doctor for a specific illness. Paths of navigation and constructions of place make what Stacey Langwick refers to as “temporal and spatial boundaries” in her work on pluralistic medicine in the former East African nation of Tanganyika (2006: 149). Spatial arrangements and paths in the landscape create *boundaries*, wherein people move in and out of place and space. The notion of *being-in* rests on the concept of a boundary, which acts as a threshold of experience. Theories of landscape and boundary rely on a certain amount of visualization and prompt the scholar to conceive of an enlivened and evolving world.

Barbara Bender writes about the landscape as having active materiality, which she claims, “sets up resistances and constraints,” (2006 303). In other words, once space is composed and defined, it then communicates those constructions. Proverbial lines (and
perhaps physical lines in the dirt and otherwise) are created as Mbararans generate or impact the landscape. With movement and engagement in space, bodies carry thought collectives and knowledge categories, and therefore actually map information over the landscape. In The Art of Anthropology, Alfred Gell has a chapter entitled, The Language of the Forest, where he argues that the landscape articulates meaning, and that symbolic forms, objects, and gesture are “mapped on to social and emotional space,” (1999: 242). Meanings and feelings are mapped onto the landscape of healing spaces, which activates place and continues the process of expressing and internalizing the lifeworld.

Landscapes, which are composed and constructed based on a group’s ideas and pragmatics, ultimately express those beliefs and utilitarian qualities. Humans are in dialogue with the landscape, and that exchange occurs through bodies in spaces.

**Stages of Spatial Embodiment**

Interactions with the landscape and with pockets of healings spaces involve multiple levels of interplay, which I have organized into three stages. First, there is a primary sensory experience that includes emotions and perceptions. Csordas claims that we can solve dualistic issues of representation\(^\text{10}\) by focusing on the “immediacy,” and “indeterminacy,” of this initial connection (1990: 2). At this stage are bare and unprocessed emotions, physiological responses, memory triggers, and sensation. A consequent relationship in the body-space conversation involves activation, definition, and understanding, which Richardson says should be approached with an “interpretive” and “interactionist” lens (2003: 75). This stage involves conscientious processing of surroundings. The third stage is the response and a resulting creation of place, which

\(^{10}\) I refer, here, to older anthropological and philosophical visions of the world as divided between the real, or physical, and the projected, symbolic nature of experience. See Csordas 1994 (pg 7 of introduction,) where he offers *embodiment* as a replacement for Cartesian dualism.
comes out of gestural and verbal, behavioral and performative expression. Reactions and incited behaviors enliven the being-in dynamic. It is, in fact, the interaction between person and place that activates and alters space, and influences the actor.

**Goals of this Chapter**

I find it fitting in this study, to look at the dynamics of space because this is an exploration of the experienced body. I argue that space forms a frame of perception. Material, visual, and otherwise sense-related components make up that frame and provoke thought and action. The felt, experienced, bodily reality is reality, and is informed by being in the world and being in place, which depends greatly on spatial compositions and immediate surroundings.

Paul Stoller is cautious and critical of ethnographic exploration of space, calling it “perceptual delusion,” but writes that the fallacy of spatial analysis as an indication of reality can be solved by a phenomenological stance, which makes “anthropologists more likely to produce [relevant] descriptions” (1980: 419). I have reported my experiences with spaces of medicine in Mbarara in Chapter 1, and I hope, here, to relay the experiences of others, which I have gleaned through my own observations and interactions, and which I supplement with ethnographic discussion and descriptive narration, which is found in more detail in Chapter 3. This study aims to reveal how being-in treatment realms relates to being-in illness itself.

Setha Low points out that we share and communicate and thusly understand the personal phenomenon of illness through metaphor, description, and narrative, and I add that we can come to know the experience of spaces by phenomenological analysis coupled with ethnographic backing (Low 1994). I offer three levels of spatial
embodiment, and I try to overcome the difficulties of interpreting others’ experiences by looking at the ways that bodies take in and reflect space through feeling, internalizing, and acting in places of care and cures. A particular reality is formulated in spaces of healing from materials and movement, and from the body’s role in the consumption of medical care.

Sensing… When First Crossing the Threshold

As people interact with and engage space, they absorb all aspects of that space from the smell of smoke or flowers, to the prick of a needle, to the humidity of a room, to the conversations around. We perceive the glaring images as well as the details of space and the objects and people present inform our experience. Places are embedded with nuance and meaning and communicate to the visitor on multiple levels. Monika M. Langer’s book on the philosophy of Maurice Merleau-Ponty reads that sensation presupposes awareness (1989: 69-71). Ephemeral aspects of a space can engulf a visitor before she realizes the factors that affect her view or mood.

In, Magic Perfume, Dream..., Alfred Gell suggests that sensory experiences, such as smell, express an entire essence or feeling beyond surface meaning, and create a sensory sphere which can surround the perceiver (1977: 30). Theories of being-in emphasize the imagined as well as the felt, and I argue that the felt can include the general tone of a place. The initial stage of spatial embodiment includes memory, and physiological reactions, such as goose bumps or salivation, as well as raw states, such as fear or content. Preliminary experience is a reflex of sorts- made up of reactive effects resulting from a communicating space.
Shuffling Anxiety

Clinics in Mbarara are adorned with institution and rooted in public throughways. There is commerce and activity surrounding the standardized buildings. They require waiting and feel cramped and rushed. The limited drugs and clinicians, and the funneled waiting spaces, give the clinics a feeling of urgency. Visitors find themselves crouched in waiting spaces and shuffling through lines. Their bodies reflect the constricting, restrictive spaces as they sit anxiously, focused only on the goal of the visit: brief moments in the confined space with the health worker. The crowdedness and hurry or the clinics is in opposition to the spans of wild landscape and easy pace of life elsewhere in Mbarara.

The pursuit of officiality, the condemning power dynamics, and the marks of standardization make clinics feel like an institution. Minimal distribution of drugs puts consumers in states of desperation, and some clinical consumers report feeling embarrassed in health centers. These factors make the health centers a last-resort choice; they are usually visited for the sole purpose of receiving free drugs. As I have stated, there are little to no diagnostics performed at HC’s and virtually no physical examination, so the path to a health center usually ends in accumulation of a common cream or generic aspirin, or it may result in a referral to a hospital or private lab, making the journey to health a bit further, or redirecting the route completely if the person has no access to transportation or funds.

After a failed clinical visit, Mbararans find themselves going back to traditional practitioners, whose places of practice feel unrushed and attentive. Time and space are more navigable and extended in these spaces. Sessions are longer and often extend into
the immediate herbal gardens, prep areas, and further “bush.”¹¹ This openness is appropriate for the types of care reflected in these spaces, where counseling or conversing and physical examination are the focus rather than expedited care and reliance on packaged drugs, such as in the case of the clinics.

Because the equipment and drugs of the local doctors are often items of familiarity, visitors feel a sense of agency. Participants report being able to question and direct traditional doctors more than clinicians, and they say that they feel more informed and more involved with their care. Many folks report going to a local practitioner in times of uncertainty because they feel that they will have the opportunity to ask questions, to learn about health conditions and their own bodies, and to guide their own treatment. This makes local healer’s homes and offices places of solace and consumers tend to seek out these places for the overall tone of a place. There is character to the healing spaces in Mbarara and an overall atmosphere that is made up of factors, such as spatial layout or depth of consultation. The medical landscape is formed by choices of healing spaces, which are often chosen out of common sense reactions and personal affections.

**Interpreting… Reflections of the Medical Environment**

Being in space prompts attempts at understanding position and place and, consequently, prompts meaning-making. Personal experiences contribute to and are informed by social knowledge and processes, and meaning is constructed through such processes. To interact with a space is to attach some definition to the space. Through utilizing spaces and classifying experiences, societies make meaning, construct knowledge, and set up and define the lifeworld.

¹¹ Bush is a term used locally to describe forests, fields, and more commonly, secluded rural areas.
Folk Conditions: Millet’s Disease

Mbararans display meaning making in their choices of health practitioners, and the ideas that they embody regarding medical practices are reflected in cultural production. For illustration I turn to a folk disease—oburo, also known in Uganda as Millet’s Disease. In children with Millet’s Disease, there are tiny particles of millet grain embedded in the chest, under the ribs, near the respiratory system that cause coughing, troubled breathing, and sometimes fever. Community members who acknowledge oburo explain that these tiny pieces come into the body out of pure tradition. They grew in people of generations passed, and millet is part of the Ugandan experience, so the body sometimes expresses this heritage or this organic connection to place by forming and accumulating some of the pieces. It is a sickness and the bits are considered ill, but the condition is innate to the Ugandan experience so it is seen as a natural development. The solution for this illness-causing matter is scoring the skin with small razor blades and removing the bits.

This skin-scoring practice is part of a generalized local method called, akushundaga that is discussed further in Chapter 4. The irritating bits of millet cannot be dissolved or treated with biomedical drugs. Clinical practitioners do not even acknowledge the disease, and many health workers claim that it is a false ideal to associate the respiratory condition with the grain, citing pneumonia as the cause for the pain and discomfort. Consequently, one must go to a local doctor, especially one who specializes in treating oburo. By doing so, the classification of this disease as “folk” becomes reciprocated, and patterns of practice are formed in the seeking of care for this illness. In this way, concepts of self, body, and disease directly inform choice of healing space and form knowledge associations.
Information gleaned in Mbararans’ treatment sessions informs further knowledge production. For example, Jenerose is a mother whose child suffered from respiratory issues. She took him to the health center and was given a lesson on cough and lung function. She no longer believes in oburo, and shares the clinical information with others. On the other hand, Peruce is a mother who has taken all six of her children to the same healer to remove millet grain. They have all been cured of coughing and chest pain due to the removal of the pieces, and she explains that oburo is a treatable disease, but that one must find the right doctor who has experience with removal.

Participation in healing practices and engagement with treatment spaces will, in theory, affect or change the body or the condition of the self. In addition, the body is influenced as the consumer takes in beliefs associated with certain types of healing and consequent acts of curing. The scars that result from removal of millet in the case of oburo treatment, for example, are visible signs indicating participation in not only a medicinal practice, but also the traditions and beliefs associated with that practice. As Lock suggests, “Social categories are literally inscribed on and into the body, which, with prescriptions…and ornamentation, acts as a signifier of local social and moral worlds,” (1993: 135). In medical practices, the body becomes inoculated (sometimes physically) with healing process and practices.

**Embodied Space/ Embodied Practice**

Bodies affected by razors, or any healing instrument or method, carry the experience of that treatment, and therefore carry knowledge (and perhaps corporeal signs) of healing practices. Conversely, materials used in treating the body are embedded with beliefs and practices, and represent curing processes and cultural ideals. I discuss this further in
Chapter 4, where I bring material back into our discussion on the dynamics of medicine in bodies and spaces.

The body not only becomes notably altered by medical practices, but one will embody a space’s arrangements, histories, and emotions through interaction. In this way, bodies take in meanings of a space and pollinate the landscape with embodied collectives of information. Lock writes, “The body, imbued with social meaning, is now historically situated, and becomes not only a signifier of belonging…but also an active forum for…expression,” (1993: 141). Bodies that sense space and hold meaning are vehicles for that bodily knowledge and couriers of experience.

Engagement in space demands a bodily presence. Spatial perceptions and responsive implications take place in the body; therefore, knowledge exists and is created in and through the body. To expand on this, I turn to another scholar of Merleau-Ponty. Carrie Noland writes about the “primacy of movement,” and follows the phenomenologist’s ideas regarding “embodied cogitation,” that are concerned with the body’s role in knowledge acquisition. This theory denies the divide between reflex and intention, and looks at any habit, reaction, or speech action as, “behavior of a responding body,” and I say, consequently, a reflection of space and surroundings (2009: 55-56). When I claim that bodies reflect space, I mean that they form physically to space, internalize meanings attached to space, and, in responding, express the experience of that space.

**Acting… Carving the Lifeworld**

Mbararans choose the spaces with which they engage based on how they perceive of self and body, illness and health, and the healing space itself or care provided. Health care
decisions are informed by prior experiences, needs, and expectations. People navigate the system of health care as an expression of preferences, thoughts, and beliefs. By doing so, they create space by attaching meaning and opinion to that space and by contributing to place.

As a society, Mbararans collaboratively maintain realms of medicine through participation in those realms. Reactions to the experience of space include reflexive behaviors, observable in body language, as well as conscientious actions and demonstrations that can be explained and interpreted. By engaging realms of care, people create the medical landscape of Mbarara. Participation in healing practices will enliven spaces and create landscape; the acting body is able to “bring about the world,” through interaction and engagement (Richardson 2003: 74). In other words, actions and choices carve the worldscape.

Movement repeatedly translates through the body,

the body translates the world (David Morris 2004: 103).

The body is fundamental to the present piece, and concepts of the body are woven throughout, but I turn to a digression on the subject, which was nearly impossible for me to delay until this point, but I find it most fitting in the final phase of spatial interactions where movement and action are key elements.

**The Body**

The relationship between body and space is, arguably, the crux of human experience. It is through the interplay between space and body that material and sensation come alive. Bodies move in and between boundaries of space, and are the expressive means of
lifeworld navigation and experience, as well as the platform for illness manifestation.

Bruce Kapferer draws on theorists like Antonio Gramsci, and sees our perceptive elucidations as informed by bodily experience and performed with the physical body. He writes, in reference to the role of the body in human understanding:

> It is within the body that the living of this experience is organized… [The body is] simultaneously the lived organized and organizing center of a historical reality which extends around it. The body [is] active and not merely passively felt. (1988: 426, emphasis added).

The notion that bodies construct meaning is particularly keen when discussing medicine and “practice that is directed immediately to the body,” (Kapferer 1988: 432). In other words, when the goal is to affect the body or perform bodywork, we are particularly aware of the role of the body in understanding, such as understanding a condition through symptomatic experience.

As Van Wolputte explains, we cannot discuss spaces without bodies or bodies without spaces. He cites Scheper-Hughes and Lock’s well-known work on personal, social, and power-based versions of bodily realities, and posits that we mediate between these with human conditions like memory and emotion (2004: 254, 253). Margaret Lock, herself, offers that the body is instilled with social information and context; correspondingly, the topographical world is inscribed by the active body (1993: 135). Bodily and imaginative reactions to space depend on logistical means within the social system, and are vectors in the continuation of that social world.

Kleinman writes about being-in illness, as a form of “being-in-the-world, that insists that experience is both within and without the boundary of the body-self,” and that health-seeking is “a tidal stream of transpersonal engagements in a local world…” (1997:
As the body is in a state of illness, the body exists within that constructed realm, which introduces a number of social and psychological connotations, such as physical limitations, search for means of improvement, and contagiousness. Moreover, the body moves as a person responds and reacts to illness, and through actions and decisions is in a state of seeking, both physically and figuratively. The body can be viewed as a biological individual, but one which relies on incorporation with a much broader network of interactions (T. Turner, 1995:145). These ideas are harnessed further in Chapter 3 where I apply them to the scope of illness in Mbarara.

**Seeking the Cure: Navigating the Medical Landscape**

The well-known concept of *habitus*, constructed by Pierre Bourdieu (1977) is helpful in discussing how people move between spaces and through the wider landscape, in a manner that creates social patterns and links social structure to practice. We can imagine the patterns as pathways through the landscape that are well-carved, directing illness-knowledge carrying consumers to treatment spaces. Van Wolputte has summed up the Bourdieu theory stream on the body in society well. He writes that scholars have, “studied the body as a medium and operator of social processes and political change,” (2004: 255). This placement of agency and ability in the body shows that embodied beliefs and human practices can actively create the world, and that the body, imbued with space-specific information, will construct knowledge boundaries and social arrangements.

Hunt and Mattingly (1998) point out that the Bourdien notion of rational and practical engagement with the world and analysis of thought through action is highly harnessed in anthropological annals, but that the study of decision-making pragmatics
takes away from the on-the-ground dealings with severe illness. They also write that experience-based literature and the politics of medical communication can be understood through “Aristotelian practical rationality,” which explores moral and teleological perspectives, as well as social and intuitive ones (Hunt and Mattingly 1998: 267-268, 270). I found that Mbararans seek care from places that will be the most effective, meaning places that are willing to treat, have the capabilities, and that the consumer can afford. These are habitual and are second nature for most, but there are other factors that influence people’s health-seeking behaviors, such as religious restrictions and personal affiliations.

Seeking care in Mbarara is not an activity met with much indecisiveness. Specific paths to treatment venues are well-carved and dictated by at least three issues. The first is the disease type, which directly corresponds with ideas and approaches to body and illness. Beliefs in folk diseases, for instance, are not universally shared, but among those who partake in folk healing, certain practitioners are well known to specialize in particular conditions or curative methods, such as the case for oburo. The second factor in care-seeking choices is political and religious affiliations and personal preferences, which are often influenced by previous experiences. For instance, the “Born-Again” Christian church, an increasingly popular denomination in Uganda, will not accept traditional medical practices, so participation in this faith restricts one’s health care options.

Various private and for-profit clinics and hospitals are sponsored by churches and mission-based agendas. This is a draw for some and a deterrent for others. Mbararans’
choices of doctors are highly informed by belief systems, and rifts in religious and lifestyle-based frameworks narrow or redirect the network of cures.

The third factor in cure seeking is an issue of logistics; availability, distance, and willingness to treat are all characteristics of practitioners that affect choice. Engagement in spaces of healing and participation in systems of health create boundaries among realms and further thicken borders around the differing health practices. However, consumers who move in, around, among, and between these realms make lines in the medical landscape and create or resituate collectives of knowledge.

**Contours in the Landscape: Realms of Health**

Langwick employs a similar visualization method to my imagined paths in the medical landscape when she refers to health care spaces and associated practices as “contours,” which she claims include medical material and parts of the physical landscape as well as regulations, people, and acts (2006: 159). “Walls…hospital policies…and jealousies”, she writes, make lines in the landscape and mark relationships and divides. She also points out that the imagining of these boundaries is useful in understanding social arrangements and political or power-based differences (2006: 162). In Mbarara, lines form around family and between enemies; contours divide the protected, or immunized, from the vulnerable; and boundaries exist around those who have powers to charm.

Contours encircle the household that include practices of illness prevention like organization of home and hygiene practices, as well as family bonds and some local treatment methods; a grid of boundaries organizes various levels and practices of traditional healers; linear trajectories lead to specific diagnostic centers and specialized practitioners; zig-zags form between biomedical clinics and indigenous doctors; bubbles
of beliefs and healing methods form to particular diseases (like oburo) and associated
treatment practices and places. Divides are drawn in the medical landscape that separate
disparate healing beliefs and practices, while some aspects from varied realms may form
connectors that bridge unlike practices. Particularly striking are those contours that mark
off the local healing realm from the biomedical in the health care landscape of Uganda.

**Power Play and Social Constructions of Illness**

Clinics, put in place by the government, are specifically infused with notions of power
that is exercised through disciplinary and shame-producing slogans and images (as well
as in a number of other ways). These institutions also create medical truths to some extent
by what practitioners are trained to understand and what health workers recognize as a
genuine illness or bodily condition. Langford writes, “Medical institutions play an
important role in the construction of core medical categories.” (1995: 331). In other
words, illnesses and healing methods that are acknowledged in clinics and hospitals
become standard and foremost medical truths.

Often, strategies and methods are similar or shared between medical realms
(perhaps because of influence, mostly of biomedicine on local practices) but ideas about
sickness and the body differ among various spheres and even within realms of care. For
example, the same symptoms are conceived of and treated differently in different medical
circles, such as in the case of cerebral malaria/ demonic seizures discussed in the
introduction of this work. Although, often, health care realms in Uganda are projected in
opposition to one another, they comprise one system and make up a multi-part medical
landscape. Through participation in various realms and through movement and sharing
between various practices, consumers combine the realms while maintaining conceptual
spheres. Biomedical knowledge (like the understanding of HIV) exchanged or used within a local healing practice shows a mixing of health care facets, but most Mbararans will maintain the differences and distinguish these as coming from varied viewpoints. For instance, local doctors may provide HIV counseling and acknowledge the disease as a modern condition; they may treat the symptoms with herbs and attribute this practice to the local healing realm.

**Incorporated Pluralism**

Rasmussen refers to consumers who embody varied realms of healing in reference to the body itself, saying that it becomes disputed terrain, whereby the body is involved with multiple realms, which physically interact within the self (2000:250). In Mbarara, for instance, *akushundaga* practices of headache relief include performing tiny splices horizontally across the forehead to release tension and painful particles. In addition, many Mbararans will take Panadol for immediate pain relief (perhaps from the cuts?) These overlapping practices mean that the body is dealing with multiple interactions and that the healing realms physically interact in the body. Following Rasmussen (2000), we can see this interaction as a potential dispute, a layering of healing realms, or incorporation of various convictions.

Medical discussions and cure-seeking behaviors that involve multiple realms of care, and the resulting exchange between them, create entwinement of healing and health-seeking spaces. In some ways, the notion of a ‘pluralistic’ system needs unraveling in the case of Southwest Uganda. The system of health care and health-seeking is multi-part and varying, but it is one system in which citizens engage multiple venues. For example, community members may seek out cough syrups from a Health Center while also seeing
a foreteller or other traditional doctor to find a social or psychological source of the incessant cough. Clinical and indigenous cures offer differing experiences of treatment, as do specific health care providers in each of these realms. Consumers create combinations of cures and some practitioners offer cross-referenced care. For example, Kuruagire is a well-known herbalist who buys headache tablets from the pharmacy, uses the medicine from the capsules in her treatments, and re-uses the capsule container to refill with dried herbal remedies.

Mr. Samuel provides another example of treatments that span healing realms. He is a bonesetter who owns a small, private office in a city center near Mbarara. Some years ago, he acquired an x-ray machine through donations from a volunteer group. He now uses traditional methods of setting and casting broken bones, but his work is informed by this machine—a biomedical diagnostic method.

Janice and Angella show yet another version of inter-realm health care. They are traditional birth attendants (TBA’s) who counsel clients with HIV and they teach methods of prevention. These women incorporate knowledge gleaned at health centers and from nursing aids who visit the local clinics. All the while, they deliver babies with nothing more than cloth and a razor, and they use their own methods during delivery to keep the disease from spreading to a newborn child, such as stretching the chord up-right when cutting, and separating the child from the birth fluids immediately.

Rather then tier systems of health care through categories or ratings, many Ugandans’ organization of treatments are based on illness-specific facilities and abilities. Sjaak van der Geest suggests that community members act as mediators of medical cooperation through engagement in multiple health care systems. (1997). The current
study supports the notion that members of these communities have highly scripted approaches to health-seeking actions, which include strategic interactions with multiple medical realms. The people with whom I spoke explained that there are specific, well-known paths to certain healing methods. There are also distinct lines between different practitioners and treatment options, which demonstrate a complex system of beliefs, religious preferences, specialization, and capabilities on the part of healing practitioners and recipients. Perhaps through growing movement between realms, medical care and comprehension becomes increasingly intermixed (and more comprehensive?) Spaces of healing are avenues for the exchange of information and are places where beliefs and commonalities bond consumers whose views coincide.

Places of treatment and healing can be considered what Isaac Jack Levy and Rosemary Levy Zumwalt called “shared emotional space,” where common ailments, conditions, and sentiment among members of a community overlap in places of care (2002:112). These communal experiences create character of space, based on what is mutually felt (body sensations such as headache-relieving cuts on the forehead, or stitches woven through the skin) and what is dealt with (themes of illness, such as spiritual or contagious,) therein (Levy and Zumwalt 2002: 112). Mbararans construct and affix meaning to locations within the landscape, and create place. Place, then, communicates, in turn.

**Spaces Act Back: The Expressions of Space and Consequent Experience**

If the built environment and our perceiveable expressions of self and culture are always reciprocating, adapting, and reflecting lived experiences, then we can follow manifestations of medical realities within the landscape and within spaces of healing.
Verbal and tangible expressions, such as descriptions of illness and medical propaganda, are indications of experiences, or proposed realities; of giving and receiving medical treatment; and, thusly, of perceptions of illnesses and therapies in general. For instance, a healer’s categorization of illness as *folk*, posters that promote faithfulness or immunizations, clinics that distribute pain killers, and hospitals that ignore ghost affliction, are all qualities of treatment places that communicate to an Mbararan consumer some pragmatic information about seeking care, but these also communicate specific concepts of illness and the body itself.

I see spaces of healing as imbued with sentiment and emotion, political and social references and expressive character, and I think that the phenomenological experience of a space includes intake of belief systems, power dynamics, history, and social organization.

Subscription to a certain healing realm may be indicative of one’s belief system or embodied practices, and consumers further the associations between certain conditions and correlating practices through participation, interpretation, and exchange. Spaces become embellished with knowledge and character, and act on those who occupy. The nature of a place is found in the material arrangements, organization, and practices that make up the overall essence of a place, including spatial configurations. Yi-Fu Tuan writes about embodied actions as *spatial skill, spatial ability*, and *spatial knowledge* whereby our very movements and motions are informed by the spaces that we occupy (1977: 67-84). In this way, we physiologically mimic occupied space and we are bound or guided by spatial arrangements.
**Blood: Point of Predation and Pathway to Purity**

Tuan discusses such absorption of place in terms of habit and skill, but I believe that people take from spaces, in the same physiological manner, perceptions of their own bodies and approaches to working with them. This self-aware, self-reflective notion of one’s own body is at the core of a phenomenological perspective. An example of a way that one may see or perceive one’s own body is found in the case of blood in Uganda. The emphasis that is placed on blood in spaces of Mbararan medicine is critical to an outlook of the body. Blood is a powerful agent of contamination as well as dis-ease alleviation. In societies such as those of Southern Uganda, blood is a central concern and a point of predation. Blood is the threshold for, and representative of, direct pollution and contact-induced infection, and it is highly associated with disease as well as ancestry, a relationship capable of imbuing one with malevolent spirits. Familial and ancestral blood is a physical connection to others, and a source of genetic disorders as well as ghostly infictions, whereby deceased ancestors enter the body of a relative and cause chaos and illness.

Mbararans identify the multiple levels of blood-related involvement in health. Many people talk about “bad blood,” that is tainted or pooled and that contains actual illness or bad fortune, such as blood that accumulates under the skin and causes pain (in boils, swelling, and bruises,) or blood that is associated with an injury (such as that which is dried on a cut or lesion,) and is therefore diseased. Blood is a somewhat stigmatized material because of associations with HIV/AIDS and because it is the site of malarial infections, but blood is more often seen as a pathway to the cure.
Intravenous injections are popular among Mbararans, but there are paralleling local methods that also target the veins for either the release of infected blood or the introduction of curing material. *Akushundaga*, as mentioned previously, is performed to cut the skin for letting blood, inserting medical media (usually herbs,) or extracting matter, such as the millet bits in the case of *oburo*. Insertion of herbs is common to provide medicine to a specific part of the body. Many healers also pack herbs into the bloodstream to cure the entire stream of ill blood, or to allow the blood to carry the cure to the whole, affected person. Because of the regard for blood’s role in curing, and due to the strong associations between the blood and illness, blood is a part of the body that provokes a person to look inward and to perceive of his body as an active, alive entity that has channels and properties of sickness and wellness, which affect the state of self and others.

This reflexive, physiological understanding of the body allows experience of self and awareness of body. This is part of a phenomenological consciousness that highlights the boundaries of and within the body, as well as boundaries that mark ill matter, and boundaries that divide being *in* sickness from being *in* health.

In this Chapter, I have discussed the ways in which bodies move in and out of spaces of healing, and now I move to paralleling notions of how sickness and cures move in and out of bodies.
Chapter 3: Being-In-Illness: The Sphere of the Sick

In painful or infected conditions, humans, “move out toward the horizons of their experience,” - Bruce Kapferer, 1988: 426.

The fundamental nature of illness serves as a particularly intuitive example of ways in which we experience lived sensations and bodily perceptions. The essence of sickness or dysfunction is bodily stimuli that prompt reaction and sentiment. Illness, pain, and disease are felt through raw bodily phenomena in the nerves and sensory matter of the body, but the experience of illness goes beyond the throbs, heat, or pangs of affected parts. Being-in-illness means that the state of the operating, sensing and acting self is compromised. It also means that an existential and reflexive reality is altered. Diseased, injured, or unmanageable conditions have effects on the way one thinks and acts. Moreover, illness affects conceptions of the lived self and the bodily being, and requires interpersonal exchange for classification and comprehension. Illness can be an encompassing sphere that surrounds the bodily self and the body’s position within a wider reality.

A lived perspective on illness brings experience into the discourse on medicine. There is a multitude of work done on illness in anthropology that tends to categorize theories of illness based on semantic constructions. These theories come from the recurring tendency in medical anthropology to use biomedical, clinical viewpoints to evaluate medical discourse, which is in opposition to the Boasian method of cultural relativism (See Hahn 1995, Murdock 1980, Pellegrino 1976). George Foster and Barbara Gallatin Anderson’s work on medical anthropology in the late 1970’s presents one standard for categorizing illness. These broad theories explain illness as either
personalistic, and caused by some spirit or cosmological agent, or naturalistic, and attributed to bodily forces and environmental materials- A frame which Baer, Singer, and Susser use to describe, “indigenous” systems which they say are likely guided by moral principles (1997:193-4). These heavy semantic networks and reductionist perspectives are what Rasmussen says can be sorted out through the notion of a “wider field landscape” (2000: 245). She calls on ethnographers to envision bodies in spaces as activated fields of experience and to allow abstractions of a lived, in-motion world.

Critical medical anthropology, a field led by Paul Farmer and others, embraces more broad cultural issues, such as poverty and colonization, for explanations of sickness and affliction. Embodied theories go further to allow the self into the explanation of illness and zoom out on the lifeworld.

**Within Illness/ Without Self**

There is a reason why sick people are classified as such and why it is easy to vividly imagine a crossing over into sickness as a departure from health- because sick bodies are in altered states, which somehow remove a person from a normal position and place him in a specific sphere. The realization (or admittance) of an ill condition allows a person to be objectified and perhaps alienated, which creates a conflicting state of self, where “The lived body thus appears to be the place where the being-for-itself [consciousness] finally confronts its being-in-itself [physicality]” (Svenaeus 2009: 55, emphasis added). An ill situation places the afflicted in a particular place that influences outlook and perceptions of self and surroundings, and this place requires some sense of yielding to sickness or at least recognizing such. In her work with the Fulbe people of Cameroon, Helen Regis conceives of those in a sick state as situated in the “role of the sick,” whereby persons
perform sickness, let go of culturally ideal policies of self-restraint and self-assurance, and therefore experience a “loss of control,” and consequently a “loss of personhood” (2003: 33-37). In Mbarara, there may not be as strict a code of principled frames of mind and behavior, but certainly shame and blame are glaring themes in the illness dialogue that I will discuss in this chapter.

With the notions of being-in-sickness and being-in health, we see another appropriate application of the boundary theme. By succumbing to or recovering from illness, we move in and out of an affected sphere, the lines of which can be bold or can be blurred. Illness, though subjective, is unavoidable, but surrendering to the role of the sick demands agency and prompts reaction. “The body is ourself” and we are particularly inclined to react and respond when we have abnormal functionality, experience hurt, or loose the grip on that self (Langer 1989: 69). The magic of our humanness is the ability to be aware of ourselves, and to understand a sick situation, even if the place of illness contains pain or grief. In fact, aching and suffering can be the most eloquent and dramatic human afflictions. They are certainly an exposé for anthropologists.

The Role of the Anthropologist in Medical Discourse

Kapferer writes, “Nowhere more than in medical anthropology is realized the embodied character of human anguish and suffering.” (1988: 426) Arthur Kleinman points out the duties of the social scientist; he posits that agony, distress, sorrow, and soreness are the “stuff of experience that summon inquiry in medical anthropology” (1997: 316). Perhaps humans are attracted to pain and hurt because they have such powerful effects, or because they inspire action, or perhaps it is just that they are challenging and indefinite concepts where human experience comes out of focus. Hunt and Mattingly suggest that by
“examining the logic…that people draw on to understand the nature of illness,” we have “a powerful context in which to consider the very notion of rationality” (1998: 267).

Bodily states of pain and sickness are poetic and personal entrances into the human experience, and conceptualizing suffering and being-in-illness proves to be a slippery endeavor. Anthropologists are in an interesting position to add to the dialogue on pain, where we already work with unraveling others’ realities and attempt to work within the day-to-day happenings of others. This gives us the chance to contribute to basic concepts in human suffering and obligates us to shed light on cross-cultural issues of health. Svenaeus emphasizes the importance of an understanding of the “lived body, in contrast and in addition to the biological ways of the body” in research and theoretical endeavors in medicine (2009: 55). Although applied and biological research is absolutely necessary for combating the spread of pathogens and crippling epidemics, anthropologists are capable of supplementing medical discourse through analysis of experience.

Feeling Another’s Felt: Understanding Experience

To understand the sensed and felt conditions of others, we rely on empathy, and perhaps our own experiences, but moreover we require symbols, descriptions, and social, “transpersonal” creations (Kleinman 1997: 320). Just as we share spaces and collectively define and fashion place, so too are perceptions of illness products of communal exchange. Whyte and van der Geest write that bodily sensations prove to be “concrete to the subject…[and] elusive and obscure” to a perceiver (1989:353). To solve this restriction in human sensing and understanding, we use devices such as metaphors and metonyms, which, “like a proverb,” will make the abstract relatable and grounded in
familiar associations (Whyte and van der Geest 1989:354). The authors point out that pain is an “indefinite experience,” and a “lonely” one (1989: 355). I add that expressions of illness require close consideration and personal reflection in order to be grasped and shared.

Persons who refer to concepts that are mutually understood by those within a cultural group relate an illness to things or ideas within the environment or the community, so even conditions that are rare or unexplainable come onto neutral ground. Levi-Strauss’ theories of naturalization come into play here. Basic forms and ordinary images are instinctual and powerful points of inspiration. He writes, “These [personal sentiments] in order to be expressed efficaciously, demand a collective expression which has to be fixed on concrete objects. (Levi-Strauss 1962: 60). What is sweeter than honey and who doesn’t know it? Metaphors of honey are found in many cultures. Uganda is no exception, where to be like honey is to be palatable, smooth, without chaos or problems as well as alluring and sweet. I can understand these comparisons because I have tasted honey and I have seen the way that it pours from a jar. Similarly, I have felt a growling stomach, bruised flesh, a sore throat, and so on. In trying to understand the experiences of the body, in Mbarara, I found my consultants and myself using metaphor often as a tool to find common experiential ground.

I rely herein on Mbararans’ own descriptions of illness and look to analyze the metaphoric and the literal expression of illness experiences in an attempt to understand experienced states for the people with whom I interacted. In this section, I endeavor to “transcend the narrow sphere of experience by interpreting expressions” voiced by community members regarding illness and health seeking (Bruner 1986: 5).
Narratives of Illness

The following biographical accounts prove that ethnographic information is not only found in direct answers to the anthropologist’s highly formulated questions, but that language and behavior provide insight into the lived experience. Laid out below are a series of quoted excerpts from interviews and conversations that either blatantly showcase feelings about health and sickness, or describe bodily conditions, sensations, and phenomenological states of affected selves. These quotes are taken from conversations and interviews, mostly translated on-the-spot by hired translators from Runyankole, and range from complete explanations to pieces of verbal expression that come out of various exchanges between myself and the people of Mbarara. The universal qualities of sick feelings and reactions to ill bodies become obvious, yet the culturally specific descriptions and personalized narratives contribute to an understanding of ideals about health in this part of the world. From the descriptions, we gain insight into notions such as severity, causation, and paralleling notions from outside of the realm of sickness, and we come closer to knowing what illness means and what it feels like for Mbararans.

These descriptions are particularly valuable as they showcase the personal qualities of the felt body, and they are each a participant’s attempt at sharing those experiences with another (the anthropologist-me). I have discussed actor-to-actor interactions and explored material-to-actor exchanges up to this point, but the accounts that follow are self-reflective; they are relational; they bring unseen and unobservable symptoms to life. Issues of invisibility are innate to the experience of the body and to wild, microscopic media of illness, but this is the marvel of the ethnographic toolkit: to bring the unseen to light. The sensed and realized ways of sickness show clearly the
phenomena of individuality, but basic interrelationships yield knowledge that can only come with exchange. Through expression, we merge sensation and knowledge, and only then can we attempt to know the feelings of another. Phenomenologist, Gaston Bachelard, explains the lived experience as imaginative and that its descriptions are inherently poetic (1964). I present this sequence of confessional and evocative fragments that are meant to relate, explore, and offer insight into illness in Mbarara:

You have to have the placenta pulled or it will poison the body.

Worms come about when you give poor food. Those worms bring about kwashikore [a type of malnutrition.]

There are the good worms, which you need, and the bad ones that cause diarrhea.

They [worms] do not like certain foods, like tomatoes, so when you take these foods, they become angry and cause stomach movement and diarrhea.

There was a rumbling in my stomach, so I knew the worms were upset.

Pain shooting up [my leg] was like twisting, twisting and grinding. grinding [twists wrists as if ringing a wet cloth].

The pain is all over… I am old. It is like - eeeek, eeeck, eeeecck - I have to walk like [squints eyes and pulses hands, palm-down to indicate slightness.]

The pain is like fire in my bones.

I came to the clinic today because the pain is such that I cannot work.

The pain was tightening and spreading.

The baby was having pierces [shooting pains] and difficulty breathing. We went to the healer and they said some ghosts of the grand[parents] who had come on the baby – they are the ones attacking her.

There are some rituals to perform after someone dies to keep that person from coming back and disturbing you, but if you fail to do those, they come back on you.

These pairs [twins] have the power to burn you…If you do not perform the right ritual when they are born, you can look at them and they burn you.
There were wounds on the inside, and when he received an injection, they came out to the skin.

Unboiled water and dust [cause headache.]

This heavy wind that blows [causes fever.]

**Some diseases come tough... they come serious and the person cannot go anywhere.**

I went out [of the house] one day and saw someone had [defecated] on the lawn. I had to remove it and when I did that charm came on me. I started to get headaches and could not sleep.

*One will develop knots in the neck and shiver in cold weather.*

_Syphilis, HIV, and allergies all come from the mother._

You become weak and that’s how you know you are sick.

*A stiff neck comes and a high temperature, with malaria._

*When you take the herbs through the mouth, it takes time...*  
*If you put herbs directly in the blood, they work faster._

_The swelling disease only attacks the hands and feet... to cure, I get herbs and tie them around the finger._  
_The herbs are tied into a cloth... The herbs suck and suck- they pull the swelling out._

_The stomach was sounding as if there was an animal in it._

The narratives are presented here to show the ways that language and description are used to explain personal sensations. Not all of them describe dire conditions. For some, pain is the arthritic pull of old age. For others, foods and other materials are clashing with the body. I include these descriptions to display the ways that pains and feelings can be shared, through the use of common themes, like fire and animals and other active forces, which I discuss further later in the chapter.

For analysis of these descriptions, I turn first to the backbone theme of boundaries, and nowhere more than in illness-stricken abstractions can we see issues of
within and without the boundaries of the body, as illness enters, attacks, or leaves the confines of the sensory vehicle and center of self. Anthropologist, Michael Jackson (1983), has famously named the skin the boundary of the body, and although I prefer to think of the body as a sphere including the physical body, it is worthwhile to note the ways that illness crosses the line that divides person from world. In Mbarara, contaminants and sources of infliction are almost always thought of as external to a person, or originating from outside of the body.

The intentions and emotions of others, the powerful and spiritual energies that surround, the environment and weather patterns, and the infected or dirtied objects in the landscape are the main sites of ill-health that impose on people who constantly work to protect themselves against the wreaking of sickness. For example, practices of bewitchment are said to “come on,” to a person from material charms charged with negative sentiment, most likely jealousy. Ghosts of deceased family members and generations passed can also “come,” and inhabit the body, but only if there is a failure to ritually protect that body through symbolic performance. Dust, heat, cold, wind, and other parts of the immediate surroundings are very common factors of ill states, that people in Mbarara discuss in terms of their being “attacked” by these things and having to protect themselves. People also mention contaminated water and food as sources of disease, which most say is an unavoidable and unceasing cause of illness.

This view of sick matter and ill inflictions differs considerably from theories of the body where illness originates from within. Daniel E. Moerman (1979) describes various perspectives of illness from his fieldwork with South Carolina’s St. Helena Islanders as, similarly to Native North Americans and northern Asians, a condition of
illness defined through properties of the body itself and imbalances of bodily qualities. Moerman uses the example of a “flavor,” of the blood, which if too sweet or bitter, can cause fainting and memory loss among other issues (1979: 60). The divide between the body and the affecting material in Mbarara seems to separate a person from her illness-causing agent. It puts space between her and the disease (van der Geest and Whyte 1989: 356). Rather than a lacking or a loss of some bodily force, such as in the case of Cherokee saliva physiology, illness in Mbarara is an invasion of some substance into or onto the body from outside (Moerman 1979:60).

“Those things will come on you:” Illness on the attack

Illness comes to you in Mbarara; you do not go to it. With the prevalence of bewitchment, ghost attacks, environmental assaults, and infected surroundings, people are in constant battle with illness. Many people say that they are “always sick,” and there is no escaping the sphere of sickness, but others see their relationship with ill matter as something that they have to prevent and from which they must block themselves. The main ways of doing so are through “organization,” strategies like persistently boiling water, closing windows, cleaning latrines, using condoms, and so on. Other strategies are more severe and more symbolic. These strategies I visit below in a discourse on witchcraft.

Charms

Through the process of crossing over, passing by, or going through a charmed area or material, bewitchment is said to come onto a person, whereby the jealousy of the perpetrator manifests into illness in the victim’s body. This form of attack is done by other persons, but only through symbolic material at the will of a powerful person, likely
an *omufumu*. People say they know that they have been bewitched if they are ill suddenly and without cause, if a sickness lasts a very long time, or if drugs and medical treatments fail to cure a condition. This type of sickness is defined as out of the hands of the inflicted, and demonstrates a *loss of self*, discussed earlier in the chapter. Bruce Kapferer (1979) writes that a bewitching interruption in the self is typical of demonic illness. He claims that illnesses contracted by the hands of another “delineate the properties of the Self...[whereby] the physiological and mental processes of the patient are disrupted (1979: 114).

In an effort to prevent these impositions and block the efforts of others, Mbararans use various forms of talismans, such as strings tied around the wrists or bellies that seem to encircle a person and mark the boundary of the body to shield it from an envious gaze or marked materials. Others keep charms at the threshold of a house or business to block any wrongdoing directed at them. In children, pierced ears are a mark of imperfection that makes them undesirable to witches, so small reeds are used to puncture the ear lobe as a sign of protection. Witchcraft is directed; it is path-particular, yet the effects range from a woman beginning to incessantly “stink,” to a man’s inability to impregnate his wife, to blurry eyesight, to the disappearance of belongings. Therefore, many symptoms and conditions that seem out of the ordinary are attributed to sorcery. Charms must be avoided, enemies watched closely, and negative attention obstructed, as the forces of others travel. If inflicted, it becomes a matter of undoing a charm, which I will touch on later and even more in Chapter 4.
This Wind that Blows

Many people blame illness on the conditions of the environment and see the general landscape as something that they must constantly tame or combat. When describing the pesky, allergy-inducing, cold-causing red dust that permeates the landscape in the dry seasons due to the crumbling of the clay soil, Mbararans say that the dust “comes at you” or that it “does not stop,” giving the dust active power and direction. The dust is seen as something that is obviously out of one’s control, but that must be kept at bay. During the dry months, it is common to go about the day with a scarf or some fabric tied around the mouth and nose. Women, men, and children are seen shielded from the red particles and taking paths less likely disturbed by vehicles, which blow storms of the powder. Car and house windows and doors are to be kept shut, and failure to cover from the dust is cause for scolding. In this way, the environment attacks; it is a villain and one is forced to keep it from entering the body.

Mosquitoes are obviously another factor of the landscape that seeps into house and home, and certainly one that attacks. Though there are many habitual precautions taken to keep these bugs away, mosquitoes are rarely demonized, perhaps because of their prevalence. More commonly, retroactive treatments are preferred for malaria because many feel that keeping from getting bitten is impossible.

Overall, illness is seen as something that permeates life in Mbarara. In an area where disease comes out of the most basic necessities, like food and water, the risk is high and prevention seems futile. Sickness is seen as an ever-looming condition that people can try to prepare for, or incorporate into daily life. Disease and death have been fairly normalized in Mbarara and Joseph Alter (1999) points out that in these cases we
are called upon to answer, “What, after all, is good health?” He asks further, if illness and loss of life are normalized, then is health necessarily a disregarded property of life? (1999: S43). For this reason, it is necessary to find definitions and perspectives on illness outside of the pathogen-oriented theories of biomedicine (Alter 1999). It is not uncommon in Uganda for folks to make jokes about the struggles that they and others endure.

A startling reality for an outsider, and a challenge for this anthropologist, was to hear people laugh at an instance of death or ignore the ailments of a child. Regis notes that in societies such as the Fulbe of West Africa, social constructions place limits on the ways that people are allowed to mourn or dread death (2003). In the case of the Fulbe, this convention comes out of person-building and piousness, but constrained emotional reactions to death also help people to deal, and they take some of the shock and devastation out of the passing of a loved one.

So, is health a central concern in Mbarara? Yes, but only insofar as it is debilitating, unfounded, or unexplainable. Other conditions are regarded as chronic or normal and are ignored. In contrast to systems such as Ayurvedic medicine, which is concerned with “overall fitness,” and geared toward “proactive” holism, health in Mbarara is defined more in terms of functionality (Alter 1999: S43). Participants in this study were concerned with pain management, ability to continue working and otherwise operating, and general functioning in society. Functioning includes the ability to “keep organized,” “prepare the home,” as was discussed earlier, and to be “strong in life,” by working to keep relationships intact, avoid jealousy and envy, prevent basic infection, and provide for the family.
Chronic Concerns and Primary Illnesses

Chronic concerns, thus, tend to become naturalized. Taking the active properties out of an illness makes it seem less threatening, and soothes the harsh reality of succumbing to a sickness. In Mbarara, only the restrictive pains and dysfunctions and the bizarre or limiting symptoms stand out and prompt concern. Chronic conditions are identified as sickness, but are less alarming because of persistence and widespread presence. From a phenomenological perspective, humans generally qualify chronic and terminal illnesses very differently than those that are curable. I make no claims to universality, but this distinction seems widespread. Many societies today experience the realities of such diseases that we understand as something that one “lives with” where there is a finality of a diagnosis. Chronic and deadly diseases seem to ultimately change the condition of the body, which throws agency and bodily self-ness into question.

“I see that he has changed”

Malaria is chronic in Mbarara. Although curable, it is pervasive and the treatments are unattainable for most. When a malarial infection reaches the point of causing convulsions or when a person becomes feverish beyond management, that person has been taken over; this state is irreversible without substantial medical treatment and it is said that the illness has won or that the person has been transformed. The experience of having something that thrives in the body or that spreads and progresses (such as AIDS) as opposed to something which fades and goes (such as a cut or a cold) is a different lived reality and forces people to see illness, the body and perhaps the person, differently. June is a mother who said of her 20-month old son, “I see that he has changed,” in reference to the physical appearance and the disposition of her sick son. June told me that her baby has
become “not there,” because of cerebral malaria, in that his focus and playfulness had
gone. She also said that he would not eat, that he “just shakes,” and had “become stiff.”
She is describing an illness taking over her son’s body, and she seems to view it as his
body becoming a vehicle for disease rather than the little boy that she knows.

**The Worms Don’t Like Tomatoes**

Intestinal worms, on the other hand, are a chronic condition that is also viewed as a
commandeering of the body, but because one lives with this infection rather than dies
from it, the perspectives of worms are different. Generally, people treat worms
themselves with simple herbal mixes, but worms return consistently and people have
varied ideas on how to deal with them. Many talk about “feeding” the worms, which is a
way to prevent them from becoming disruptive and causing issues like diarrhea and
“rumbling,” or churning, stomachs. Folks explain that by eating certain foods, and thusly
feeding the worms, they noticed an aggressive reaction to certain things, like tomatoes.

There are “good worms,” and “bad worms,” some say. The good ones are
necessary for the functions of the body, and the bad ones make you sick with diarrhea.
These theories of intestinal worms from Mbararans sound much like what Edward C.
Green (1994) found in Mozambique and among the Tswana of South Africa, who
describe cases of diarrhea as a cleansing prompted by the Nyoka, or snake in the stomach.
Green draws a connection between intestinal worms and the stomach snake, which
people are born with, protects the body, and, like the worms, becomes agitated by dirty
food and bad medicine, causing cramps and noises in the stomach (1994: 13). By
attributing pains and sickness to some thing inherent to the body and which serves a
function in health, it seems that Ugandans and South Africans may be naturalizing some
part of the illness landscape that is unavoidable and kneaded into the everyday. van der Geest and Whyte write that by naturalizing an illness, the communities “depersonalize,” that illness (1989: 353-355). Illness with ambiguity or anonymity feels less effectual. To normalize an illness lessens the selflessness that comes with ill states, and it eases the sphere of sickness.

**Blame, Shame, and the Unfortunate**

Of the debilitating illnesses in Mbarara, all seem to be associated with either blame, which looks to those factors outside of the body which I’ve mentioned; shame, which is spoken about as a “failure,” to prevent an illness or be prepared for a situation; or something “unfortunate,” which is usually describing illness and bad events that are impersonal, unexplainable, or really terrible.

When a person becomes afflicted with an illness or disease, they will usually think first of bewitchment, especially if the condition is unprompted. Illnesses that are attributable to mal-intending persons and negative spirits are particularly offensive and approached with substantial fear and distrust. Blaming others for ailments is a reciprocal practice, because bad relationships come from blame and thus further blame is enlisted. There is what I refer to as the “dueling healers” phenomenon, whereby feuding community members enlist the expertise of separate traditional healers who make charms and conjure spirits against their client’s adversary, taking the bad relationship even further.

Shameful situations are those that are perhaps unavoidable, and are talked about as a failure to carry out some preventative measure. Mothers are often burdened with

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notions of shame, many citing that “poor feeding” (serving a mono-food diet) bad house habits (like using unboiled water) and back-to-back pregnancies which limit breast milk production, are their guilt-ridden downfalls. I believe that some of the shame associated with home prevention comes out of the education and sensitization programs at places like the government health clinics. Failure to prevent bewitchment and ghost embodiment are also a common source of trouble. When someone believes himself to be cursed or inflicted with spirits, he may say that he has failed to perform the right rituals to prevent this from happening, such as the ritual that keeps a ghost confined to a burial site in order to prevent it from wandering into a living descendant’s body.

Particularly severe or solemn events are explained as unfortunate. These are conditions that are beyond one’s coping abilities or when there are multiple problems at hand. Mbararans also explain something “unfortunate” if it does not involve them and they choose to be uninvolved or withhold comment, if something is troubling with no direct solution, or if it is simply unexplainable. For example, when a child dies of malaria this may not be considered, “unfortunate,” but if the child’s disease progresses much more quickly than usual or if malaria came onto more than one member of a family at the same time, it is unfortunate.

Susan Reynolds Whyte (1997) presents, in her work with the Nyole of Uganda, that issues of uncertainty and misfortune arise when life does not unfold as it should or as predicted. She applies the same notion of failure that I have attributed to shame, to various cases of misfortune that she organizes as “failure of the good life,” which includes failures of health, prosperity, gender (gender specific issues, like pregnancies) and personal safety. Whyte explains misfortune not as suffering, but as reflections on

**Approaches to the Unfortunate: The Healer’s Position and the Researcher’s**

In some ways, to recognize an event or a condition as unfortunate is to make it a source of reaction. Though these are instances clouted in uncertainty and seen as beyond one’s control, they also provide points of change or adjustment. Whyte points out that the definition of misfortune, unlike statuses of chronic illness, implies an agent that can be attuned. For this reason, misfortune leads to “sacrifices… rituals, and manipul[ion of] medicines…to alleviate” the imposing conditions that afflict (1997: 21). Whyte (1997) calls for medical anthropology that follows-up with these therapies, because although they may fail, they do more than serve symbolic roles which interest the outsider.

Behaviors and processes meant to remedy misfortune are not done as performance or to construct social relationships. They are meant to cure sickened states and ease anguish (Whyte 1997: 21). Because issues of misfortune are a part of the challenging reality in Uganda, with limited resources and widespread vectors of illness, these practices are riddled with doubt, but they are curative and restorative, nonetheless (Whyte 1997: 22). The next chapter explores healing factors and looks at the symbolic nature of cures.
Chapter 4: Tablets and Injections: Medicine’s Materiality

The value of medicines seems to be based on a perception of them as having an inherent power to heal.
- Susan Reynolds Whyte and Sjaak van der Geest (1989: 350, 353)

[Humans] achieve healing through manipulating symbols so as to alter the state of the physical and social body.
- Steven Van Wolputte (2004: 255)

To bodily, ill conditions experienced within the self, there are counterparts outside of the bodily boundary, often in the form of, or represented by, material items. Medicine is emblematic; it signifies a passage out of a state of sickness. Medical practices rely on objects and imagery for reinforcement. Moreover, medicines help people to classify, comprehend, and maneuver illness; “Medicines enhance the perception of illness as something tangible, which may be manipulated” (Whyte and van der Geest, 1989: 346).

The following discussion on medicine and healing is intended to rejoin this thesis to the subject of materiality. I argue that relationships with medicine mostly involve interaction with material and that we tend to look to something outside of the self for relief—something that breaks the boundary to the sphere of the sick; something that delivers the body from dis-ease.

Jean Langford describes diseases and bodily dysfunctions as “entities enclosed in an individual body” (1995: 331). If we think of illness as a whole-an entity that affects the entire body, then medicine is meant to change the status of, and to reinstate, the self. Medicines allow persons to look to something separate from the affected body to bring the self out of a certain state. Medicines carry the afflicted out of the position of the ill and are meant to transform the circumstances of the bodily domain. Medicine can be an escape from sickness and ill impositions, or medicine can be a power-induced product or
performance that acts on the body, reverses sickness, and that cures, cleanses, or releases bad and painful states.

**Alluring Affections: The Attraction of Medicine**

Because of medicine’s capabilities to provide relief in desperate and uncomfortable circumstances, and because medicine can bring the afflicted from states out of one’s control, medicine has allure as do those who provide curative means. Csordas describes traditional healers as *charismatic* in his work, *The Sacred Self* (1994) and although he refers to the intimacy and drama associated with traditions of persuading and influencing spirits and bodily states, I would extend this concept to suggest that whether healing is sacred or mundane, especially if it is elusive or forlorn, it entices. Those in need are drawn to the possibilities of bodily interference and to active and transformative processes in the body and in the spirit world.

Whyte and van der Geest, in *The Charm of Medicines*, argue that medicine is an extension of a healer or doctor’s power, and that medicine as a *thing*, or object, carries strong symbolic associations and has influence (1989:345). They write that the charming quality of medicine “arises from [medicines’] concreteness as substances” (1989: 345). The authors discuss mainly biomedical pharmaceuticals in places deprived of sufficient medical supplies (like Southwest Uganda) but the notion applies to drugs in general. Medical materials are “liberating” because of their physicality and, often, their mobility (Whyte and van der Geest 1989: 348). They provide self-ness through a cathartic transference that leads to individuality and control over one’s own body; Medicines are “eminently transactable” (Whyte and van der Gesst 1989: 348, 350). Medical materials can be exchanged and often rely on interpersonal relations. Medicines can be
commodities and can move, and the acquisition and consumption of medicines depend on cultural constructions, social structures, and symbolic communications.

**Medicine Objectifies**

Medicines provide analyses and conceptions of illness, and this contributes to their charm. Whyte and van der Geest (1989) argue that the ultimate draw of medicines is its connections to that which is experienced, yet mysterious.

Medicines help people deal with symptomatic and experiential conditions of sickness and mediate between patient and practitioner. The intermediate realm between physical manifestations of illness and lived states of sick or well is structured through medical matter that symbolically represents a classification of sickness as well as a decided effort to heal.

For instance, In Uganda, because of the unimportance of diagnoses, people generally classify conditions based on the medicines that they are given or those which are recommended. An elderly woman with whom I spoke told me that she was visiting the health center because of pain in her abdomen; she was given a well-known drug that treats syphilis, so her assumption, though she had no formal diagnosis, was that she had syphilis. Medicines help to classify more than illness; they contribute to classification of the self. There is a phenomenologically different state of being for someone suffering from disease than someone undergoing treatment. Ezekial is a 50-something year old man who has suffered from varicose veins for some time. He tells me that he was first very confused by and worried about the severe swelling of the veins in his legs, but that now he has an herb that is meant to thin the blood and increase circulation. Though he had seen no results from the herbal regime at the time of our meeting, he insisted that he
is no longer consumed by the condition and that just knowing that he has some medicine makes him more content. “The mediation of the body’s… change through the physical incorporation of medicines is integral to the social construction of personhood” (Green 1996: 485). Medicines help construct the self in terms of changing bodily positions from sick to well.

In *The Sorcerer and His Magic*, Claude Lévi-Strauss discusses the mystery and the symbolic nature of healing, which he writes is informed by *belief* that is constructed and maintained by *symbols* (1998:129). Lévi-Strauss argues that even if healing is practiced through symbolic representations, it is real. There is some intangible action or idea between getting infected, bitten by a mosquito for instance, and experiencing symptoms, malarial fever for example. Medicine can be the corporeal placeholder for happenings between biology and surroundings; medical materials are vehicles of “objectivizing [and] formulating… inexpressible [and] inarticulated experiences, (Lévi-Strauss 1998: 131). The experience of consuming medicine is reliant on targeting a sickened state, and medicines help us to deal with bodily happenings, which are often invisible or beyond our human senses.

Not only do drugs, “as substances, change the substance of the ailing body,” but medicines operate in reference to a corresponding illness, and thusly help to conceptualize bodily states and feelings. In other words, “the existence of therapeutic substances invites the concretization of ill-being” (Whyte and van der Geest 1989: 355-356). Medicines are mediators of meaning and their firmly defined forms help fill in for the uneasy, indefinite qualities of illness. Medicines offer a prop that allows an afflicted person to place power and reliance on something outside of herself. With medicines,
people can impart agency to a material object, which takes the focus off of the body – the very thing that is the site of the concerning injury, infirmity, or misfortune.

For instance, I often encountered people in my fieldwork who when asked about a condition or any changes in an ill person, would respond with information about the medicines that they are taking or giving. That conversation sounds like:

Me: “and do you still have the fungus?”

Interviewee: “I have a cream.”

This does not tell me anything about the actual condition of the fungal infection, but it communicates that treatment is being given, so the responsibilities and actions are shifted over to the medicine (the cream).

**Embodiment and Medicine**

Through interaction with spaces and materials of medicine, people can assimilate properties and affections of those materials. Brad Weiss, in his article on false, or “plastic,” teeth extraction in Tanzania (a practice also found in Uganda in which a practitioner rids the body of illness-causing extra teeth) writes that through embodiment with practices of healing, consumers go through a process of “thinking through” the teeth in this case, or other symbolic and material forms (1992: 538). In this way, visible matter acts as a cue for healing and conceptualizing illness. Weiss claims that the body is defined, constructed, or “produced, through its various forms of engagement, as an objectification of meaning power and the like” (1992: 544, emphasis added). Through exposure, use, and interaction with material means in the medical landscape, health care participants define illness, self, and experience, and these embodied practices are expressed through further symbolic displays.
For instance, patients who have undergone processes of *oburo* extraction will have a series of tiny horizontal scars in the middle of the chest. These lines are indications of one’s experiences and beliefs and are physical marks of embodiment in curative practices. Terence Turner, who has done ground-breaking work on the subject of body treatment and adornment, refers to a consumer with bodily signs of medical engagement as a “socialized actor,” and he writes that these marks are “signs of the cultural boundary” between body and world” (1995: 146). I would add that the scars are messages that continue the body-material cycle in that material acts on the body and the body expresses as material. These actions and signs make up the representational conversation of medicine in Uganda.

**Medicine Acts**

Medicines interact with, affect, and presumably change the body. Bodies take in and take up medical material through the blood, stomach, skin, saliva, and other bodily substances. Through utilization of medical instruments and tools, bodies also become imbued with material through inference and implication. Medicines, as materials, enter the body directly (physically and biologically) as well as through figurative embodiment. Material, the fabric of the medical spaces in which consumers engage, acts upon the body:

1. interactivELY- through nuance, messaging, and representational form, and
2. symbolically– through social acts of healing, which are ways of manipulating the material world and instilling material with intentions, energies, and character.

Medicine acts on the self, either through physical introduction into the body or symbolic practices that incite physical change. Medical interaction with the body is informed by the nature of an ill condition. I have discussed practices, such as *askushundaga*, which
rely on extraction to release accumulated water and air in the body and that can drain
sickened matter; approaches to medicine such as this one depend on the presence of
illness or illness-causing materials inside the body that must be removed. Other
medicines can be ingested or introduced into the body somehow as to affect the entire
bodily sphere. Medical treatments may move to some particular part or channel within
the body, or they can involve actions that aim to move the body from a certain state. In
any case, medicines depend on their pathway to the body; medical materials are effective
only as they cross bodily boundaries. Curing is about getting the bad out and getting the
good in.

**Out with the Bad/ In with the Good: Bodily Boundaries and Material Interaction**

Illness may be identified as a substance or thing within the body, such as millet bits in the
condition of *oburo*, in which case healing hinges on getting the substance out. Matter that
is inherent to the body but identified as tainted or sickened, such as the way Mbararans
conceive of bad blood, also depends on getting substance out from the boundaries of the
body. Bad blood, in Mbarara, is attributed to bad fortune and bad relations among family
as well as blood that is exposed to or associated with injury or sickness, as in the case of
Fred who suffered a motorcycle accident that resulted in broken bones.

**Blood Gone Bad**

Fred explained to me that the places where there was bruising after his accident and
places where the bones were broken were sites of infection. He said that stemming out
from these areas, especially where the bone had broken through the skin, were sites of
blood that had “gone bad.” The bonesetter who treated Fred sucked from his wounds the
“dark blood,” and therefore made the “good,” or new, blood flow through the body, thus
cleaning the sites of infection and starting the process of healing the abrasions. In this way the nature of material within the body is attributed to sickness or wellness, depending on its exposure to ill matter, association with trauma or infection, and time-specific issues like regeneration. I discuss concepts of blood in more detail later in the chapter.

**Bodily Ridding Practices**

Bernard, the herbalist discussed in Chapter 1, relies on the concept of purging to heal and cleanse the body. He says that in order for his medicines to be effective, he must first get out the substances that are causing illness in the first place. He utilizes specific agents of extraction—botanical materials which cause the body to have a natural, physical reaction. For instance, Bernard grinds spicy chili peppers and other herbs down to a powder and has children take a series of sniffs of the powder so that they sneeze and release accumulated debris and illness-causing pathogens in the nose, sinus cavities, and even further into the forehead, where Bernard says headaches form. After getting the ill matter out and clearing the passageways, he administers soothing honeys and herbal waters for allergies, headaches, and congestion.

In a similar treatment method, Bernard administers tobacco leaf enemas to force diarrhea, which he claims is useful for getting out bad worms, spoiled food, and sickened stomach matter. In this case, Bernard will again follow the extraction with administration of honey, herbs, or warm water in order to put the good back into the body. The medicine that Bernard practices is best described in clinical terms as *internal*, which, according to Robert Hahn is the “mind, if not the heart of Western medicine—Biomedicine” (1995: 174).
Getting bad materials out and good materials into the body delineates the striking boundaries of the body to which I have referred throughout the present work. This also highlights the individuality of the body and the divide between the self and the rest of the object-world (T. Turner 1995: 146). The idea that the body has formed, obtained, or accumulated bad material seems to suggest that there is a natural state and that extraneous matter is problematic. It also suggests that the state of the unseen, inner self is to be regulated and maintained, and that intake alone cannot cure.

**Medical Consumption**

Intake, however, is central to a discussion on medicine in Uganda. In cases where healing necessitates affecting the entire self or where there is no specific body part or bodily matter with which to work, (as in cases of malaria, bewitchment, and colds) medical consumption is necessary. For the most part, in rural government health clinics in Uganda, there is not much discussion of the internal workings of the body. There are practically no physical examinations, no ways of looking into the body, such as x-rays, and no surgeries, extractions, or testing of bodily matter. Medicine in the clinical sphere in Mbarara looks outward, to materials, objects, and substances outside of the body to treat the body and as a platform for dealing with illness.

**Looking Beyond the Body**

The steady mantra voiced by consumers at the time of this study (2009) was “tablets and injections,” in reference to things that make one well or healthy. Resoundingly, in questionnaires and interviews, patients and community members told us that these two forms of medicine are what works; these two methods of material healing are the paths to wellness; these are what cures best, quickest, and most efficiently, and this is the type of
medicine that consumers want (2009 MHIRT study). Injections, in particular, are associated with instant relief or reversal of infection or disease. Injections, which are used in a range of applications, from vaccinations to quinine treatment for malaria, are said to be on-the-spot therapies. The substances dispensed from the tube of a syringe are viewed as “strong,” “intense,” “tested,” “fast,” “measured,” and “powerful,” and these qualities are all equated to genuine and successful health treatments by Mbararans.

**Introducing Medicine into the Body**

The notion of taking material into the body feels phenomenologically different than forcing material out. Taking medicine in is associated with treating the existing body, whereas extracting matter out seems to affect the condition of the body in an attempt to get it to a normalized state. Even Bernard, who rests the success of his practice on extraction, claims that getting material out is only half of the battle. To treat the body is to apply materials or energies to, on, or in the body.

Clinical injections and tablets are meant to treat the body and alter the state of the body by getting some thing from outside of the body to act from within (fig. 18). Introducing materials into the body often calls for further material means, namely- tools which are used to affect the body and make medicine cross the body boundary.

**Paralleling Medical Realms**

The razor pictured below is the exact razor that is used in *akushundaga* and other local healing practices in Uganda. Not only is it useful for scoring the skin to extract matter like millet and for letting out infected blood, but it is the tool for opening the skin to get to the veins for inserting herbs and other substances that are meant to flow through the body and through the bloodstream, just as injected drugs are meant to do. Both the image
of the razor and that of the needle are iconic representations of materials that are associated with specific treatments. Besides literal, microscopic interaction with manufactured chemicals and plant essences, bodies are notably affected by materials used in healing processes.

Fig 18: Needle and Razor Blade
Images were used in pile sort activities and interview processes as props for discussing associated treatments, they show parallels between objects used for affecting bodies, specifically through the blood stream, from biomedical practices (injecting medicine-left,) and local healing (extracting as well as inserting matter- right.)

The medical objects that touch and manipulate the consumer affect the body in a very evident, tangible manner- through physical, sensation-based contact. These materials become associated with certain cures and are then understood as medical and curative things, in and of themselves. In Uganda, there is a certain relationship with the items pictured above, and that relationship demonstrates a level of material-body interaction beyond that of biological interactions. The tools used in medical practice are particularly tangible, concrete measures of healing and health constructions; therefore, they are subject to physical-visual impressions.

This bodily interaction is part of what James Dow calls the “transactional” nature of symbolic forms, such as the needle or razor (1986: 64). Dow claims that healing
interactions that are based on “culturally established” media rely on the “emotional value” of medical material in addition to the utilitarian value (1986: 64). I would add that material that we physically use to influence the body and the lived self has particularly poignant properties. Due to the use of the medical material in affecting one’s being, objects such as the razor become substantiated expressions of healing methods and curative knowledge networks in addition to being material that is used to physically manipulate the body.

**Object Affections: Medicine as Thing**

Byron Good (1994) writes, in *Medicine, Rationality, and Experience*, that a medical system will *construct its objects*. He follows the philosophy of Ernst Cassier in conceptualizing illness networks as formative of imaginations and perceptions, suggesting that objects of medicine are creations, symbolic of experience as well as activity (1994:69). Objects used in medical practices become figurative forms that represent not only illness constructions and healing practices, but also bodily being and lived sensations. In Good’s words: “Illness combines physical and existential dimensions, [therefore] medicine as a form of activity joins the material to the moral domain” (1994:70).

Good’s work on medicine and experience looks intently on medicine as a symbolic form, primarily in that medical conditions and therapies are constructed and organized through language and symbols (1994: 67, 88). He explains that our conceptions of body, illness, and healing inform the objects and symbols that we use and create to cure and to explain sickness, and he goes on to write, “Healing activities shape the
objects of therapy—whether some aspect of the medicalized body, hungry spirits, or bad fate—and seek to transform those objects through therapeutic activities…” (1994:69).

The complement to the personal, imperceptible nature of illness is the sharable, tangible nature of medicines and symbolic healing materials. Christopher Tilley explains in his chapter of *The Handbook of Material Culture*, that objectification of material is accomplished through “exchange, appropriation, and consumption” whereby the users of objects produce the objects’ substantiality (2006: 61). Medical consumers objectify drugs and other curative materials by their dealings with them as well as through their reliance on such articles of healing.

Medicine as object is an important concept when we talk about the attractiveness and the power of medical material. Whyte and van der Geest point out that drugs, particularly manufactured pharmaceuticals, “objectify the healing art of physicians and make it into some-thing that can be used by anyone” (1989:348). Drugs can be a product that one can have, keep and use, and this is a powerful capability in a place like Southern Uganda, where there is not much to have and to keep. Therefore, the object-ness of medicines, specifically those from the biomedical sphere, are particularly appealing to people in Uganda, and I argue that this is due to more than just the perceived effectiveness of the treatments. I came to see that the medicines as articles are fascinating to people in Mbarara as they may be to people in many places. Is one any less pleased with a visit to a doctor’s office if we leave with no ‘stuff”? Packets of drugs given out at health centers are a major accomplishment for people in Mbarara. If they can leave a visit to the HC2 or HC4 with something, they have gained a material possession and have
achieved a successful interaction with a practitioner; they also now own something that represents health or healing and consequently may view the ill condition differently.

The objectification of medicines and medical materials make them into icons, and therefore images and representations of treatment substances are equally appealing as they are indications of actual objects and curative matter.

**Medical Iconography**

Because of medicine’s active ability to alter one’s self and bodily state, medical imagery and objects are given compelling properties. Materials associated with curing and bodywork are emblematic constructions that showcase experience and the lived body. In this way, the image of the needle does more than represent an actual injection. It references the clinic at which the injection was given, the experience of the prick of a needle through the skin, and the resulting changes (presumably curative) in the body and in the person; it references a certain sickness, or a spell of sickness, and (hopefully) a specific movement into wellness.

The physical interactions, and the symbolic interplay, between bodies and objects of healing showcase the dynamic abilities of material to act on the body. Healing objects become more than the literal tools of medical treatment; they become logos of medical care. So, physical manipulation of the body by material is formative of figurative and perceptual experience as well as biological alterations.

**The Almighty Needle**

From an image-based pile sort activity, I found that needles are most closely associated with cures and healthy states. People in Mbarara, almost across-the-board, chose the picture of the needle (fig.23), from a collection of 12-13 pictures displaying items that
had been formerly expressed as associated with health and prosperity, such as herbs, nurses, and sanitary water. Images of needles were resoundingly chosen as a preferred and as a most effective treatment for disease and prevention. In Chapter 2, I claim that spaces of healing are imbued with symbols and references. I also claim that these symbols act on the consumer, reference treatment, and affect experience. The walls of clinics in Mbarara are covered in images of needles (fig. 25-26) for everything from promoting immunization to campaigns that caution against reuse. I suggest that just by being in spaces adorned with these symbols, a certain medical and bodily reality is invoked, or, at least, expectations for care are formulated.

I have explained the attraction to injected medicines and the demand for this form of treatment, and point out that this attraction may be due, in part, to the fact that spaces of biomedical care are infiltrated with images of needles. As Adome, Whyte, and Hardon (1996) and van der Geest and Whyte (1989) have indicated, there is a strong, powerful
presence of manufactured and privately-sponsored pharmaceuticals in the clinics of Uganda. This presence may sway perceptions of effective health care treatment.

The needle images within the spaces of health care in Mbarara both reference care and reciprocate the potency of the needle icon. Medical materials can carry strong messages and infer interaction through powerful imagery and symbolic forms. In this way, the relationship between bodies and material is extended once again. We move now from physical interaction (medicine in the blood, and reflexive blade-to-skin encounters) to nuanced affections where the allusions to medical care can act on the body (picture of a razor blade that triggers thoughts of healing or memories of treatment).

**Inferred Affections: Medical Messaging**

Materials embedded with history or action can affect a consumer just as material that is used to physically manipulate the body can. As I pointed out in Chapter 2 where I analyze the dynamics between spaces and bodies, the body becomes imbued with surroundings and with details from the landscape. Medical material and nuanced medical forms communicate to health space participants a certain situation and experience, and emblematic forms of medicine can actively set up and define the experiences of medical spaces. People embody the material with which they engage, and absorb the politics and character of medicines, perhaps in rural Uganda more so than actual manufactured or prepared medicines, due to the limited quantities of drugs. Places of healing and treating illness in Mbarara are imbued with symbolic material, which can be felt and experienced and which affects people’s understandings of sickness and cures.

The body is in contact with medical material, which acts on the consumer through social and spatial interplay. The dynamics of embodiment in places of healing are
diverse. As I argue in Chapter 2, *Navigating Medical Realities*, there are symbols and meanings infused in the healing spaces that contribute to the experience of medical treatment. Material composition and resulting experience of space make up medical knowledge collectives that affect medical care and perceptions of medical material.

**The Green and Blue, Red Cross**

The red cross symbol, for instance, has become a general sign for health care in the region and has been placed on pharmacies, private doctor’s offices, and emergency vehicles to indicate such (fig 20). The simple cross, embedded in the walls and spaces of the clinic suggests ‘legitimate’ medical aid. Authentic or trustworthy medical practices in Uganda, I am told, are identified by lab-tested drugs, formally trained doctors, and standardized care, all of which are assumed features of biomedicine.

In the aforementioned pile sort interview activities, I found that a red cross-type of design in any color indicates emergency care or organized, biomedical treatment. My hand-drawn crosses were identified with clinically equipped places of health care, and rightly so as they have purposefully been used to represent private clinics, pharmacies, and the like. It seems that with the presence of the cross icon, consumers assume a particular kind of care. I believe that spaces and embedded material messages communicate ideas of health, power, and illness-fighting agents to consumers. I am not suggesting that the presence of images like needles or crosses directly make Mbararans feel well, but that they contribute to the experience of the spaces and affect perceptions of place and care.
Judith Butler argues that matter has personality and history, and that materiality is constructed through use (2007:165). In reference to the body’s interactions with signs and symbols, Butler claims that a symbol “produces an effect [that is] productive, constitutive, and performative” (2007: 166). Through the use of the Red Cross symbol in the past and its presence on ambulances as well as health care organizations and emergency outposts, people in Uganda have become used to seeing this sign in places of care and health treatment. Ugandans who now use the symbol in their businesses and places of treatment understand its concise and effective iconography, and consumers may look for the sign when seeking care or embody the history and meaning of the sign within spaces adorned with the symbol. Butler claims that the “power [of material] operates in the constitution of the very materiality of the subject” (2007: 170). In other words, the cross symbol has meaning and therefore power because of the ways that people interact with it, utilize it, and interpret it.

Objects associated with curing and medical discourse become symbols of care and representative of not only systems of medicine but also specific, bodily experiences.
Mbararans take in medicine and medical iconography through proximity and spatial embodiment in addition to physically swallowing, bathing in, or inserting medicines. van der Geest and Whyte point out that medicines, particularly packaged and distributable medicines, carry the experience of a healing space and even as medicines are “removed from their medical context, they retain a potential connection to [the healing space]” (1989: 359).

This notion of materials having the power to carry sentiment and association touches on work by Janet Hoskins, which I first referenced in the Introduction of this thesis. Hoskins argues that materials have biographies, and that they can absorb and thereby transmit culture and ideas (2006). Byron Good writes that materials embody ideas and belief systems and do not just represent them in the context of his work on semiotics and medicine, where he says that medicines “translate across medical systems” (1994: 89). Curative practices can be accomplished by imbuing materials with intention and character, whereby the materials are given active properties that affect people as a reflection of the objectives and actions of the ones making the medicine.

The symbolic processes of charms that affect the body have already been discussed briefly in the discussion on bewitching practices in Chapter 3. Practices of making and ritually charging materials for use in charming and other psycho-social processes clearly illustrate the highly symbolic form that medicines take. These are materials so full of emotion, intention, and character that they physically change people and bodies.

Healing and influencing the state of one’s being in Mbarara greatly depends on creation, manipulation, and characterization of materials that symbolically enter the body.
through figurative action whereby emotional and lived qualities of experience cross into the body or wash over the body to cause, or to treat and reverse, illness. Rasmussen (2000) has found that for the Taureg peoples of Niger, medicine, similarly, comes in the form of emotion, intent, and energy. She writes, “Medicine among Taureg involves guarding powers…blessing power, almsgiving, and generosity” (2000: 262). Medicines can take the form of thought, will, or feeling; as long as it is meant to affect the state of the body, it is medical.

**Symbolic Affections: Intention as Medicine**

Perhaps the most obvious forum for discussing the representational, performative, and active properties of material is in dialogue on the subject of spiritual and symbolic healing. Withholding details of symbolic healing until this point was met with considerable difficulty, as the essence of spiritual healing, for me, is material literally inundated with powers and active characteristics.

Even for spiritual and ritual healing that attributes sickness to societal intentions and ghostly invasions, as in jealousy or ancestor embodiment which cause physical symptoms, it is necessary for curing to become visible or perceivable in order to be believable and effective, so there remains a reliance on material for symbolic, ceremonial medical affections. Christine Greenway reports on a certain healing tradition among Quechua speakers of the Peruvian Andes. She found that in certain soul-calling ceremonies meant to cure fright, that the medical bundles used in the healing processes “embodied [the] patient’s changing condition” (1998: 156). Materials can have agency and character due to their histories and handlings (Hoskins 2006,) or materials can be the decided transporter of thought and action. In Greenways’s example, the medicines
actually represent not only wellness, but the journey from sickness (1998). In Mbarara, medical charms, just as those created to curse or bewitch, are prepared by professionals who place action and abilities into material items in order to cure. Healers who create medical talismans intend to instill life and objectives into substances, and those substances then carry and represent bodily transformation.

**Stepping Over the Drugs**

Evidence of materials with character and intention is found most clearly in an example of symbolic healing in Uganda, which also shows the ability for material’s imbued sentiment to breach bodily boundaries and cross into the self. Bewitching practices, common among all classes, ages, and categories of people in Mbarara, are processes by which pain, misfortune, and disease are inflicted through figurative material means. Herbal packets, or amulets meant to charm, are given dangerous and powerful qualities through a process of spiritual transmission from a socio-medical practitioner to a hand-held bundle, which then carries the power of the spirits, the healer, and the herbs. Bewitchment can only be achieved through bodily interaction with the manipulated materials. The one who means to curse another will do things like hide the activated charms under his enemy’s steps or somewhere on the property where he knows his enemy will walk.

The body must interact with the materials- it must pass by or over, and therefore *take in*, the materials and their associated intentions, feelings and potential physical manifestations. This physical embodiment of sentiment is based on a figurative relationship between bodies and material, and the performative actions of medicines, in this case, are based on character and intention *entering* the body. This both differs and is
in keeping with what Maia Green reports from Tanzania (1996). She says that “people’s bodies are permeable… and through ingestion of harmful medicines,” witches can attack, but this loss of self is also achieved by witches who “eat people by consuming their vitality,” which is not something that I know of in Mbarara (1996: 493). In Uganda, I found that material and embedded objectives penetrate the body to cause bewitchment. For people with whom I spoke, charming is a matter of curses in the form of an attack or intrusion rather than a figurative loss on the part of the afflicted.

Bewitchment practices are not performed solely with herbs and ‘native’ items, though this is mostly the case. A paralleling process of charming is achieved with packets of manufactured drugs from Kampala (Uganda’s capital city,) and drugs imported from India, Europe, and beyond. The pharmaceutical medicines are symbolic of the dangers and potentials of the illnesses that they are meant to cure, so stepping over a medicine will activate the associated disease. For instance, a packet of “Cipro” (short for Ciprofloxacin, a fluoroquinolone tablet used in the treatment of many issues from chest congestion to acute malaria to urinary tract infections) can be used as a charm to cause the very conditions that it is used to treat.

**Ill Affections**

In the practices of using charms to cause sickness, intentionality is carried out through material media. Through proximity and spatial interaction, the body takes in illnesses and conditions through a mediating material object. Van Wolputte calls this “a process of simultaneous reproduction and transformation” (2004: 255). Sentiment and thought (and practice, and therefore culture) are reproduced, and the condition (and therefore the personhood,) of the receiver is transformed. With practices of charming, incidental bodily
intake of ill affections is achieved with otherwise everyday materials (like dried leaves and thread) that, when combined and associated with action and emotion, characterize mal-intentions, sickness, and bodily transformation. In rites of stepping over the drugs the embodiment process, though figurative and symbolic in nature, depends on physical body-material interaction.

**Lifting the Charm**

The only solution for charms that have “come on you,” is to have them lifted by a practitioner who can perform analogous ritual treatments. Bewitchment can be lifted sometimes with a simple purchase and ingestion of herbal medicines that cure witch spirits within the body, such as those offered to Franceen, the lady who visited Dr. K for a consultation in Chapter 1. Most often, though, the cure for a charmed state is to have the negative emotion and the physical manifestations of ill intentions extracted through processes of ritual removal, which involve bundles of herbs and other materials that are imbued with protective energies. Along with the symbolic words, actions, and spiritual contact that the practitioner performs, these materials are meant to chase off the presence of the witch as well as prevent further attacks.

**Shield from the Charm**

The protective bundles that traditional doctors provide for a handsome sum are carried around in pockets and clothes; wrapped into small pieces of fabric which are worn around the wrist, ankle and stomach; and placed at the threshold to a home or place of business to block witches and ill intentions. In the photo below, I am trying to show the baby’s protective belly string. His mother had it made by a local healer and it contains herbs and ritually charged soils that keep bewitchment off of him.
These material bands, strings, and other materials literally encircle the person and provide a figurative shield that, with the powers instilled by doctors and practitioners, are visible signs of ritual action. Those who have the protective talismans rely on material to enforce bodily strength, vitality, and health. Medical materials have strong performative abilities and powers of symbolic treatment, and the materiality of medicines provides visible, even artful, ways of expressing a denial of illness and a statement of the self, of health, and of one’s place outside of, or without, sickness.
Power in Performance: The Art of Medicine

Steven Feierman writes that “healing is a mysterious process” and that the “patient’s total emotional state, social relations, and culturally conditioned understanding of illness all have something to do with healing” (1985: 106). Successful treatment of disease may depend on the power of the botanicals and chemicals in a drug, or the powers and energies that either back up or galvanize social and symbolic therapies. Feierman explains that, as Mary Douglas and others have posited, medicine depends on “social negotiation of symbolism,” and this is particularly true of African healing systems, where “medicine is deeply embedded in social life” (1985: 106). Van Wolputte’s view is in keeping with this perspective; he writes of the Tshidi peoples of South Africa, that “they achieve healing through manipulating symbols so as to alter the state of the physical and social body” (2004: 255).

Van Wolputtem emphasizes that these processes of curing demonstrate both a transformation of personal states of being for those involved as well as a reciprocation of shared cultural symbols and processes (2004: 255). As material is engaged and activated, it is given powers to affect. In this way, the material landscape is created, harnessed, and built as an expression of cultural beliefs and practices. The material world acts as mediator between interpersonal, experienced beings. Signs and symbols within that material world are both indications of processes, interpretations, and actions as well as props for further engagement and interpretation. Bodily signs of health and healing, such as scars that result from akushundaga and adornment like the body strings are visual signals of embodiment and expressions of belief sets. They are results as well as cues from and for interaction with materials and others.
Medicine, as a symbolic form, is indicative of the relationship between bodies and material, is representative of medical knowledge, and shows the ways in which we conceive of medicine and medicine’s place in the experience of illness and health. Medicine is symbolic; transversely, symbols can be medicinal. Medicine plays a role in the experience of sickness, and, in the spaces of treatment, medicine sets up boundaries between the sick and the well. Medical materials are suggestive of embodied conditions and states of wellness; therefore, the power of medicine extends beyond the direct healing effects of the curative substance.

Endnotes

1 The notion of extraction, explored in this chapter, extends to ritual practices of ridding the body of ghosts and demons performed by spiritual healers. Such practices of extraction demand a conjurer to persuade spirits, thusly pulling out the negative forces and clearing the body; the parallels between these ridding practices deserve investigation, but that is best reserved for a separate thesis.
Conclusion

This thesis is an investigation of the cyclical relationship between bodies and material. It is about the lived state of illness and the symbolic nature of medicine, and the dynamics of the relationship between the two as they come together in spaces of health care in Mbarara, Uganda.

Through exploration of and in medical spaces, I have explored some of the experiences of being sick and seeking care in Mbarara through discourse on notions of experienced being. I find that conditions of illness highlight the lived state of the self. Sickness, much like space, is something that people embody, that surrounds, and that researchers can study phenomenologically. The concept of within and without the boundaries of the body found in anthropological annals and throughout this thesis extends to spaces of healing, where consumers find themselves in referential health, as well as to affected bodily states, which I conceive of as the sphere of the sick. Bodies in illness prompt the need for medicines in bodies or matter extracted out from the body, which often puts affected bodies in spaces of health care.

I argue that the spaces of healing affect the health-seeking experience through nuance and messaging. Central to the composition of healing places are the visual and sensed media present. In this work, concepts associated with theories of material culture are applied to medicine and bridged with theories of the symbol. The materiality of medicine and the symbolic nature of curative means contribute to perceptions of healing and of self, and also set up the experiences of health care spaces.
I paint a picture, through thick description and photography, that allows the reader in to the spaces of medicine in Mbarara, and I pluck from those spaces items, symbols, and emotions that stand out to me and that contribute to the experience of being in the spaces.

I explore linguistic and personal expressions of sickness in Uganda in order to be able to talk about what illness means in the area and how sick and well bodies are conceptualized and classified. Through analysis of sickness narratives gleaned from my fieldwork, I attempt to explain not only how illness is described in Mbarara, but also how sickness feels and what type of reflexive experience it brings. Perplexing states of sickness and dis-ease are not only, at times, mysterious to the afflicted, but are only imagined or empathetic concepts to another. Health care consumers have the challenge of communicating ill conditions, and I have found that health-seekers in Mbarara have language and patterns that allow them to share lived states with practitioners as well as with the anthropologist. I also find that sickness constructions are highly hinged upon health care infrastructure and authoritative medical practices.

Expressions of self are the keys to understanding in ethnography, and so I use social interactions and performative materials as venues of expression that inform my study. Working in traditions of ethnographic exploration, the present work relates literature on medical anthropology to the scholarly lineage of phenomenology. By approaching health care and healing from the viewpoint of the spaces, this thesis makes material culture and the landscape relevant to a study on curative practices. I aim to bring the lived body into dialogue on medicine in order to allow further understanding of the experience of being in illness and the pursuit of being in spaces and conditions of health.
References


*Phenomenology & Practice* 3(1): 6-25.


Sartre, Jean-Paul. 1956. *Being and Nothingness (H. E. Barnes, Trans.).* New York: Washington Square Press. (Originally Published 1943.)


Vita

Kara Miller was raised along the oyster beds and salty docks of coastal North Carolina by parents who fed and fueled her curiosity and creativity. The granddaughter of rural tobacco farmers, Kara was interested early on with people’s interactions with their environments. Her focus on social and psychological aspects of the human condition was furthered by undergraduate studies revolving around all aspects of culture. In 2006, Kara received Bachelor of Arts degrees in both general anthropology and applied visual arts, *cum laude*, from North Carolina State University, where she minored in psychology. Following graduation, Ms. Miller traveled through Northern Africa and Latin America where she conducted small research projects and did volunteer work. At that point, she knew that she had a genuine love for scholarly explorations and a thirst to engage with people. In 2008, Kara was accepted into the graduate program in the Department of Geography and Anthropology at Louisiana State University, where she instantly felt at home among discussions of cultural landscapes and embodied spaces.