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Authorization and illegitimation among biomedical doctors and indigenous healers in Tanzania

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Abstract:	This paper analyzes interactions that took place during a set of workshops involving biomedical doctors and indigenous healers in northern Tanzania which promoted the use of indigenous knowledge in public health education and training. Such workshops are needed since, despite their success in treating patients for a number of health problems, healers are still misrepresented in the media. In the context of inequality, then, the purpose of the workshops was to encourage the participants to learn from one another and to find ways to collaborate so that they could better treat patients in their area. The analysis assesses the efforts of the non-governmental organization that organized the workshops to create a culture of inclusion and equality among the doctors. The analysis shows how both parties are first legitimated through narratives of equality in the official discourse of the workshops. Subsequently, however, the healers are delegitimized in their interactions with the biomedical doctors through unequal forms of address and through the conflation of indigenous healing with witchcraft. The analysis shows how inequality in discursive practices is a key site for enduring struggles over symbolic power, even in contexts where equality is explicitly on the agenda.

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1. Introduction

This paper explores symbolic (in)equality in the context of public health by exploring how a group of biomedical doctors and *waganga* ('indigenous healers')[1] in northern Tanzania navigated their professional identities in the context of a health initiative that aimed to encourage greater collaboration. Good working relations between biomedical doctors and healers are important to cultivate since, according to the World Health Organization (WHO) the ratio of biomedically-trained doctors and nurses to patients in Tanzania is 1:20,000 people, while the ratio of *waganga* to patients is approximately 1:350 people. In Tanga, the site of this study, Tanzanians rely on *waganga* even more, as the ratio of biomedical doctors and nurses to patients is even higher at an estimated 1:33,000 ((Kasilo et al. 2005; Mwakitwange & Bashemererwa 2008). Because of their faith in healers, and due to long distances to biomedical clinics, poor roads, and the prohibitive costs of transportation, an estimated 60% of all Tanzanians visit healers as their first course of action when seeking out medical care (Mhame 2004). In the 1990s, a non-governmental organization (NGO) was formed in Tanga after a German doctor working there noted that many patients visited healers prior to visiting him. This doctor initiated a referral network with local healers and hospital workers who later established the Tanga AIDS Working Group (TAWG), an NGO dedicated to the prevention and treatment of HIV/AIDS. The nature of the communication among TAWG-associated healers and biomedical doctors and nurses who work at clinics and hospitals is the focus of this study.

Researching communication practices in public health contexts has the potential to shed light on the successes and failures of public health initiatives as they unfold in discourse. It can also unveil the more subtle ways that certain health professionals are accorded with institutional legitimacy while others are not. In studying the potential of collaboration between biomedical doctors and healers, power differences play a central role, not only in the genesis of health initiatives, but also in the potential of these efforts to succeed. Biomedical doctors enjoy a privileged status in terms of their relative wealth, educational background, and social status. Their medical training and methods for treating patients are not questioned for their legitimacy. On the other hand, though healers have treated patients for centuries, and harvest and dispense proven cures for malaria and other chronic health afflictions, their legitimacy has regularly been

[1] The more common term *traditional healers* will be avoided here since it places healers who are working in the present within a framework oriented to the past and devoid of innovation or syncretism. Moreover, it generalizes all non-biomedically trained health practitioners as having a shared set of knowledge, which is not the case. In this paper, I will follow McMillen's (2004) use of the term 'healers' to refer to those who have been trained in a range of non-biomedical medicinal practices and who use plants, animal products, and other remedies to treat physical, mental, and spiritual diseases.

questioned since the colonial era, when the British criminalized their activities and conflated healers with *wachawi* ('witchdoctors') (Langwick 2011; Mesaki 2009).

The analysis I pursue in this paper is based on the idea that global public health initiatives (GHIs) are largely discursive in nature, both in policy and practice, and that more discourse-based work is needed to help uncover the workings of these initiatives in order to critique and transform both policy and practice. In reviewing the social science literature on NGOs and GHIs, Doyle and Patel (2008) describe the research that does exist as superficial, concentrating on variables that are easy to measure, such as attendance at meetings, number of condoms distributed, or number of workshops organized. Doyle and Patel (2008:1936) call for more studies on "the content, mode-of-delivery, and effectiveness" of interventions as a way forward. Hence, the key goal of the study is to assess how health education efforts that seek to redress inequality and improve the contexts for providing healthcare are faring.

2. Discourses and knowledge systems about HIV in the Global South

Despite the high prevalence of HIV in the Global South, discourse-based research in contexts such as sub-Saharan Africa is a recent development. Applied linguists have begun to turn their attention to HIV/AIDS in these contexts, focusing specifically on the creation of knowledge as it is constructed in language and multimodal semiotic systems (Higgins & Norton 2010), and on tensions and conflicts that can be traced to divergent epistemologies and different modes of sharing knowledge. For example, in both Burkina Faso (Drescher 2007) and Tanzania (Author, 2010a), it was found that local norms and cultural beliefs about HIV were often disparaged by peer educators at the expense of promoting WHO-sanctioned life skills, thus causing target audiences to take on a skeptical attitude toward the prevention messages. On the other hand, in Uganda, Norton and Mutonyi (2007) found that performances about sex, risk, and disease in school-based HIV/AIDS youth clubs gave students a platform for discussing stigmatized and taboo topics more openly. Black (2012, 2013) examines how an all HIV-positive Zulu choir in South Africa used different types of joking mechanisms, scientific terminology, and English-infused isiZulu to confront stigma and assert a positive attitude toward living with the disease in the context of stigma.

While healers are not necessarily stigmatized for their professions, they are clearly second-class citizens with respect to biomedical doctors in terms of their education and forms of treatment for HIV. Author (2014) found that in NGO-sponsored educational events that included healers, biomedicine was consistently privileged, and indigenous perspectives were downgraded and even ignored. Though opportunities arose multiple times for workshop facilitators to draw on the knowledge of healers and relate it to the official curriculum, these opportunities were either bypassed or allowed to fizzle out. This study raises the question of what can happen in a context where knowledge sharing and equity are explicit institutional goals, and where differing worldviews on health are not just acknowledged but also valued in official ways.

3. Analytical framework

The analysis I present here is inspired by Laclau and Mouffe's (1985, 1991) discourse theory, which allows me to examine the struggles to fix meanings in the world of public health workshops about HIV/AIDS prevention. Following Laclau and Mouffe, I examine the meanings produced as a web of processes in which meaning is created. I am interested in the validation and potential restructuring of different types of knowledge, and particularly, in the inclusion of what the NGO refers to as 'indigenous knowledge' about health and healing. The aim of this analysis is to map out the processes by which the NGO facilitators and the participating medical professionals grapple with an intercultural meeting space and the process of struggling over meanings as they seek to be inclusive and respectful of each other's different professional identities.

Four of Laclau and Mouffe's (1985) central concepts help to establish the larger goals of the paper and are illustrated in Figure 1. First, a *discourse* is the fixation of meanings within a particular domain – in this case, the discourse is biomedicine and the domain is public health. For them, "Any discourse is constituted as an attempt to dominate the field of discursivity, to arrest the flow of differences, to construct a centre" (1985: 112). The hegemony of a biomedical discourse linked to HIV/AIDS prevention and treatment is precisely the reason for the series of workshops, as the healers have largely been left out of institutionalized efforts to provide care for Tanzanians. Within the discourse of biomedicine are what Laclau and Mouffe call *moments*, or signs that become more or less fixed through hegemonic processes, but which are always capable of being contested (these appear as 'm' in Figure 1). Some of the moments that are relevant in the discourse of biomedicine could be 'white blood cell count' or 'viral load'. The NGO context examined here attempted to create moments in discourse that would be inclusive of healers, including the Swahili term *waganga wa kisasa* ('modern healers', to refer to biomedical doctors), a retronym coined to point out the existence of Tanzanian healers (*waganga*) long before the development of western biomedicine. Following Laclau and Mouffe, a discourse is formed by the fixation of meaning around *nodal points*, which are privileged signs that in turn produce a hierarchy of relations with other signs. As Phillips and Jorgenson (2001) explain, in the field of biomedicine, the discursive construction of 'the body' is a nodal point to which signs such as 'symptom,' 'tissue' and 'scalpel' acquire their meaning and become *moments*, or meanings which are closely attached to the semantic fields of the nodal points. Other signs are *elements* ('e' in Figure 1) if they are polysemic or unfixed within a discourse.

In accord with post-structuralist theory, then, discourses about HIV are produced through a net of signs, and other forms of knowledge (such as spirit world-based understandings of health and healing) are excluded from this net. Discourses, nodal points, and moments in the world of indigenous healing are left in the *field of discursivity*, where they remain excluded, but also as a resource for later possible articulations. In Tanga, the NGO facilitators made remarkable efforts to establish more equality for indigenous knowledge by bringing in semiotic resources from the field of discursivity, where indigenous perspectives on health and healing were circulating, and highlighting the very contingent and constructed nature of the meanings in already privileged signs in the discourse of public health.

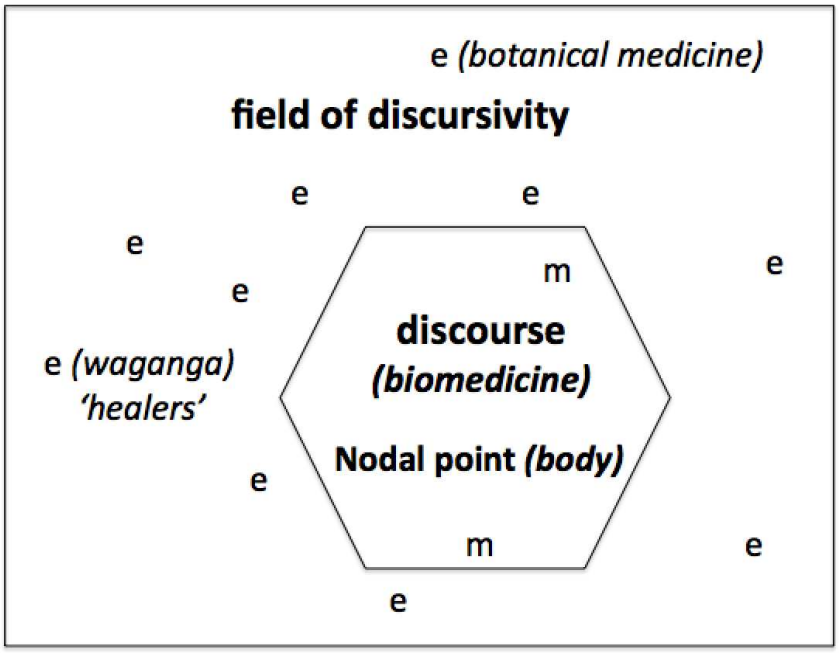

Figure 1. An illustration of Laclau and Mouffe's theory of discourse ('e'= element; 'm' = moment)

Laclau and Mouffe were interested in analyzing how the structure of society is constituted and changed by looking carefully at the nature of discourse. In a parallel manner, I am interested in examining how the structure of public health systems in Tanzania are constituted, challenged, and also potentially changed for the better. Of course, bottom-up change is arduous within a system that received millions of dollars of funding from biomedically-oriented donor agencies such as the World Health Organization, Oxfam, and UNICEF – but as the examples in the data presented here show, there does appear to be room to maneuver within these frameworks for including other discourses and meanings. To examine these processes in discourse, I turn to Bucholtz and Hall's (2005) framework for sociocultural linguistics and two tactics of intersubjectivity that they relate to institutional aspects of identity. First is their concept of *authorization*, which involves the affirmation or imposition of an identity through structures of institutionalized power and ideology, which I apply to the ways the NGO facilitators legitimate indigenous knowledge and the traditional healers. I examine authorization by studying how the NGO workers represented the knowledge base of the traditional doctors through 'demythologizing narratives' about medicine and healing practices. These narratives were set up to present indigenous forms of healing as not only equivalents, but as precursors, to contemporary biomedical approaches to healing. I then explore the other side of the coin by illustrating how *illegitimation* works in the workshop discourse to dismiss, ignore, and perpetuate hegemonic structures. Here, I demonstrate that discursive practices such as the vocative use of 'doctor' to refer only to the biomedical doctors ran counter to the egalitarian ideology previously espoused by the NGO workers. Moreover, the occasions of authorization that took place were characterized by the biomedical doctors' acts of legitimating the healers' practices, rather than vice versa.

4. The context of the study

The data analyzed in this paper come from a series of workshops that took place in 2010 at a health clinic in Maramba, a small town in the Tanga region of Tanzania. Tanga borders Kenya to the north and the Indian Ocean to the east. Most residents are Muslim, and while Swahili is a dominant (and the national) language, the main language of many residents is either Digo or Sambaa, names which also refer to two of the predominant ethnic groups in the area. The facilitators were Swahili dominant, and so the workshop was carried out in Swahili, with some codemixing in English. English is officially the medium of instruction for secondary and tertiary schooling, but many Tanzanians who have graduated from high school have very low mastery of the language (Brock-Utne 2005). While the biomedical practitioners who participated in the workshop were highly proficient in English, the healers were not. The doctors and healers were fluent in Swahili and possessed some degree of proficiency in local Tanzanian languages, with healers being more proficient than biomedical doctors and nurses.

The workshops were sponsored by the Tanga AIDS Working Group (TAWG), the only NGO in Tanzania that explicitly promotes the use of 'indigenous knowledge' in public health education and training, and which works to advocate for traditional healers. The purpose of the workshops was to encourage the biomedical doctors and the healers to learn from one another and to find ways to collaborate so that they could better treat patients in their area. Approximately 25 people participated over the week-long workshop that I attended, with slightly more healers than doctors in attendance. The workshops that I attended took place as TAWG's program was in its third year, heading toward the stage of 'capacity building' – NGO-speak for the expectation that participants in any training or educational event will ultimately take on the work that the NGO has been organizing as their own and will find the resources they need, rather than relying on the NGO (or donor agencies) in the future. Over the three year period, TAWG had conducted workshops and seminars separately with each group, and over time, they brought them together to build collaborative relationships.

The workshop was held in a conference room at Maramba's governmental health clinic. Two facilitators who worked for TAWG shared the task of teacher-centered instruction at the front of the classroom and used powerpoints to lecture about the history of indigenous medicine in Africa, the differences between healing and witchcraft, the methods by which healers harvest their medicines from plants and trees, and the referral system that had been set up by TAWG so that healers could officially send their patients to clinics. The health professionals sat close together at long tables and seemingly chose to sit in self-segregated groups of healers and biomedical personnel. Each person had their name affixed to the table in front of them, which was noteworthy because the doctors included the title "Dr." on these name cards. The workshops ran from mid-morning to late afternoon with several scheduled tea breaks. The facilitators included group work each day in the workshop which encouraged the doctors and healers to brainstorm and problem solve, and the last day of the workshop ended with group work dedicated to collaborations for the future.

A brief historical context of the workshop is of course also essential for interpreting the way that the events unfolded, particularly because the colonial history of Tanzania has left a long legacy on the legitimacy of healers. Upon taking over Tanzania from the Germans after World War I, the British instituted an ordinance in 1928[2] against witchcraft that prohibited anyone from distributing medicine to communities. This legislation was crafted to prevent organized uprisings against the colonial government and had the effect of re-categorizing many healers as *wachawi* ('witchdoctors'), which in turn impacted how Tanzanians themselves came to understand the two vocations (Langwick 2011: 47). While *waganga* are understood as healers who diagnose sick patients and treat them with plant and tree-based medicines, it is generally agreed that witchdoctors deliberately strive to cause harm to others through sorcery, curses, and other forms of magic (Mesaki 1993). The lines between healers and witchdoctors were not so clear to the colonial officials, however, as some healers have also been known to treat people who have been cursed by witches (McMillen 2004: 891) while others use biomedically 'invalid' treatments such as *kombe,* a medicinal practice brought to Tanzania from the Arab world in which the healer acts as a medium for spirits and writes in red saffron ink on a plate to diagnose a patient. The ink is added to water and is then treated as medicine (Langwick 2008: 434). As the data below will reveal, healers' continued adherence to practices once mis-identified as witchcraft have made it difficult for those who are trained in biomedicine to fully trust their colleagues.[3]

Despite the damage done to healers by the colonial governments, the Tanzanian government has taken many steps to validate indigenous medicine. After independence, the country rejected the colonial prohibition on healing practices, established a professional association of healers, and created research institutes that served to (re)legitimize the healing powers of indigenous medicines. In the 1970s, as part of the socialist policies of the new government, a traditional medicine research unit was established at Muhimbili Hospital in Dar es Salaam. Researchers and government medical officers primarily collected samples of natural remedies and interviewed healers in order to catalogue their knowledge in the hopes of using it widely across the country. In the 1980s, the socialist economy crumbled and the government succumbed to structural adjustment programs in order to receive financial bailouts from the IMF and World Bank. These programs required shifting from a government-sponsored healthcare system to a fee-for-service system, which had a positive ripple effect on healers. Because the World Bank and United Nations expected Tanzania to liberalize its economy while also striving for improved public health as a marker of development, these institutions promoted the use of healing as a means to

[2] This legislation is still in effect in Tanzania (Mesaki, 2009)

[3] Additional reasons for distrust are due to economic competition in the world of indigenous medicine that came along with liberalization and the requirement of cost-sharing after the IMF imposed structural adjustment programs in the 1980s. To make profits, unscrupulous and untrained healers began to offer 'cures' for HIV/AIDS, and many feared that the natural medicines they used would be stolen by outsiders and turned into expensive pharmaceuticals that they would not benefit from and which Tanzanian patients themselves would ultimately not be able to afford. Indeed, Tanzanian *Artemisia*, which is a natural remedy for malaria, is already being manufactured in China, regulated by the Tanzanian Food and Drug Administration, and patented by the Tanzania Patent Office (McMillen 2008b).

that end (Sindiga, 1995; Langwick, 2011), and the collaborations facilitated by TAWG are one such example of that development.

3.1 Data Collection

TAWG's institutional identity as supportive of indigenous knowledge led me to pay special attention to any social identities marked as 'indigenous' that might be afforded to the participants at the workshops. To study these identities, I took field notes and audio recorded the events, paying attention to the ways that the workshop positioned the biomedical and traditional doctors. I already had a solid familiarity with public health education and workshops among educated, urban populations from my previous research (Author 2010a, 2010b, 2014), and I adapted these to the new context. Though I am fluent in Swahili, I hired a Tanzanian research assistant to accompany me and to help me capture the details of the interactions, to take photographs, to fill in cultural gaps, and to act as an additional pair of eyes and ears. Later, my research assistant graciously helped me to transcribe excerpts of data and to occasionally shed light on contextual aspects of the activities that we were examining. I was also able to discuss my analysis with the facilitators of the workshops since the director of TAWG was my official research sponsor while I was in Tanzania.

4. Analysis

4.1. Authorization

I first examine *authorization*, or the institution-based discursive construction of legitimacy, by studying how the NGO workers represented the knowledge base of the healers through 'demythologizing narratives' about medicine and healing practices. These narratives were set up to present indigenous forms of healing as not only equivalents, but as precursors, to contemporary biomedical approaches to healing. One of the strategies used here by the facilitators was to show the participants a powerpoint of images of plants and trees that have been acknowledged by biomedical science to treat diseases and ailments, including for malaria and high blood pressure. The facilitators showed images of a herbal clinic in Ghana, which illustrates how an herbal clinic operates within a biomedical hospital, much in the same way that TAWG's own clinic works at operates in the city of Tanga at a government-funded hospital. All around the clinic are trees, bushes and plants that are known remedies for a variety of medical problems. This led to several additional examples, which I discuss below.

4.1.1. Authorization: Establishing commonalities in the biomedical and spiritual worlds

In the facilitators' presentation on the first day, the first session was limited to the biomedical doctors and was led by Dr. Saba (all names are pseudonyms). He mentioned the Hippocratic Oath as a way of pointing to an example that blended biomedical practices with historically religious and/or spiritual origins as a way of inviting the biomedical doctors to consider the field of medicine's rather multifaceted foundations. This led him to raise the example of the Eye of Horus, which, in his telling (and in tellings by many others, albeit not without controversy), is

the historical basis of the Rx symbol underlying modern medicine that is used in prescriptions (see Figure 2). The Eye of Horus is an ancient Egyptian symbol associated with healing powers.[4] Another reading of 'Rx' is based on the Latin word *recipe* or 'to take.' The point of providing this example was to underscore the links between biomedical healing, religion, and the natural world – and to challenge their separation in the usual discourse of biomedicine.

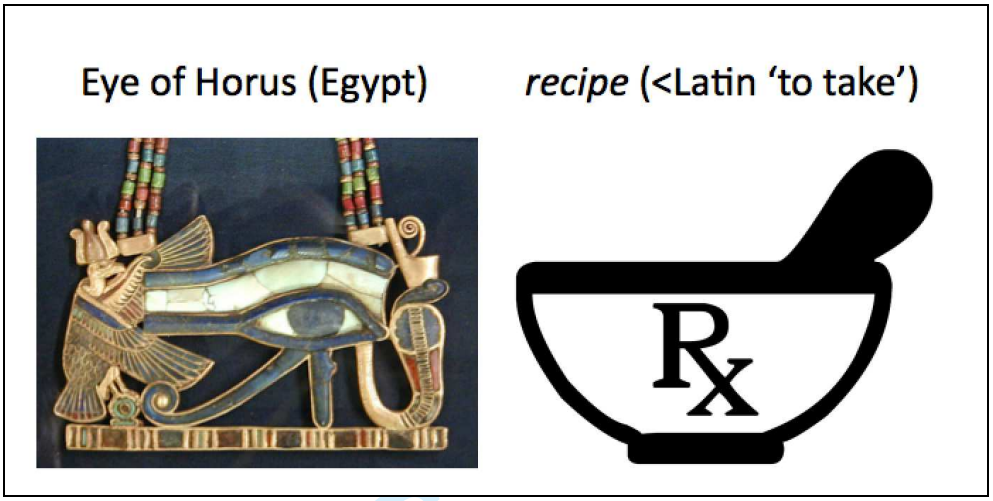

Figure 2. The Eye of Horus compared to the Rx symbol in biomedicine. Copyright free images courtesy of wikicommons.

4.1.2. Alignments with the authorial discourse

Unfortunately, the talk about the Eye of Horus was not recorded, but the conversation immediately following this example demonstrated how the doctors took up Dr. Saba's points about the common ground he was building – or *authorizing*, as an NGO facilitator with an internationally funded project. After Dr. Saba told the group about how to prepare one type of indigenous root, Kingazi, one of the biomedical doctors, exclaimed in Swahili (which is translated here),[5] 'We see that you have already become an *mganga* [an indigenous healer]. After an agreement by another biomedical doctor, Kingazi offered the timely use of "*Allahu Akbar,*" ('God is great'), an expression that is widely used in the Islamic world to express appreciation, among other more religious meanings. Here, its use was in appreciation of Dr. Saba's many talents, including his deep knowledge of indigenous medicine including ways of preparing botanical medicines. In all of the transcripts that follow, biomedically trained participants are indicated with (MD) after their names, and healers are indicated with (H). Transcription conventions are adapted from Atkinson and Heritage (1984).

[4] As the story goes, an ancient Egyptian God Horus, whose eyes were said to represent the sun and the moon, had his eye torn out in a battle. A god associated with the moon restored the eye, which resulted in a widespread belief that the eye had healing and protective power. The eye was then depicted in many places and it was used as an amulet.

[5] I have opted to provide translations that are not literally word-for-word representations but instead provide readers with an understanding of the original sentiment while also conveying that sentiment in unstilted English.

Extract 1

1	Dr. Saba:	Ili kuepusha kuchemsha sana dawa za asili wengine wanasema msitumie
2		less than fifteen to twenty minutes. Kwa sababu ukichemsha overheating pia (.)
3		material yanapotea. (1.0) Tunaelewana jamani? Mmelewa. Au (m)nasema
4		tu? Maanake mnaendelea na mambo yenu.=
5	Many:	=Tunakuelewa.
6	KingMD:	>Tunaona umeshakuwa kama mganga.<
7	Dr. Saba:	Eti eh?
8	IssaMD:	Kabisa.
9	KingMD:	Allahu Akbar.
10	All:	((congenial laughter))

1	Dr. Saba:	To avoid overboiling the medicine some people say that you should boil it less
2		than fifteen to twenty minutes. Because if you boil, you are overheating (.) and
3		the (healing) material gets depleted (1.0). Do we understand each other? Do you
4		understand or are you just saying so? I mean (.) are you not really listening.=
5	Many:	=We follow you.
6	KingMD:	>We see that you've already become like an *mganga* ['healer'].<
7	Dr. Saba:	That's right, huh?
8	Issa(MD):	Completely.
9	King(MD):	God is great.
10	All:	((congenial laughter))

Like most of the participants at the workshop, Dr. Saba is Muslim. Nonetheless, the expression of "*Allahu Akbar*" here is not so much a serious comment, but more of an intertextual alignment with his points about the difficulty in distinguishing between beliefs and biomedicine in many contexts.

4.1.3 Local languages and address forms as authorization practices

As an act of affixing signs to meanings in the discourse, Dr. Saba regularly invoked the healers' knowledge base as he facilitated workshop sessions by asking them about ethnobotany, medicinal plant preparation, and treatment of patients. He also asked the healers for the names of treatments in local languages such as Kisambaa, which in turn authorized these languages as pathways of local knowledge. He found ways to emphasize that healing predated biomedical forms of knowledge, and he used several examples in which biomedical practitioners had simply built off of indigenous medicine's accomplishments. In the example below, he compares the idea

of refrigeration with the practices of healers, and he uses the address term "Dr. Sulab," to call on a healer, in line 5 to provide the term.

Extract 2

1 Dr. Saba: Mfumo wa msingi wa taalamu ni- msingi wa taalamu ni msingi wa
2 utengenezaji eh? Kuna mafriji hapa. Friji. Unajua friji ni lugha ya asili.
3 Ni 'magunia' tu tunatumia. Ni 'magunia.' Endapo tunaonyesha moja lakini
4 hapa kumefutika bahati mbaya. Hii ni jinsi ya kutengeneza friji kule kwa
5 itwaje- kwa Dakta Sulab (.) sijui inaitwaje?

6 Many: Silambo. ((Kisambaa term))

[lines omitted]

18 Dr. Saba: Kumbe inaweza ikatengenezwa baada ya walivyoona ile (.) walivyotengeza
19 friji.

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1 Dr. Saba: The system of the foundation is- the foundation of expertise for preparing
2 medicine, right? There is refrigeration here. Refrigeration. You know
3 'refrigeration' is indigenous language. We say 'burlap sacks.' 'Burlap sacks.' We
4 had one (word) for it but unfortunately it was lost. This is the way of making
5 refrigeration ((in Maramba)), what's it called in- Dr. Sulab (.) what is it called
6 ((in Kisambaa))?

7 Many: Burlap sacks ((in Kisambaa)).

[lines omitted]

18 Dr. Saba: Wow, so it's possible (modern refrigeration) was made after (foreigners) saw
19 the way (.) the Sambaa created refrigeration.

While many of the participants actually answered Dr. Saba's question, including biomedical doctors who also know the Kisambaa language, Dr. Saba's framing of the knowledge positioned the healers as knowing the answer. Moreover, his question authorized Dr. Sulab the Kisambaa language and the practice of *silambo* ('refrigeration by way of burlap sacks') as relevant and worthwhile for the workshop and did so by treating Dr. Sulab as an equal among his peers. Throughout the facilitator-driven sessions, Dr. Saba and his co-facilitator consciously used "Dr." for everyone. They also used the innovative address term *waganga wa kisasa* for the biomedical doctors, which translates as '(indigenous) healer of modern times,' and is a rather novel re-affixing of a meaning to a sign. By using the address form *waganga* as the default term, the facilitators can be seen as moving the term into a central role as a "nodal point" in Laclau and Mouffe's terms, rather than leaving it as an element that can take on a (usually) pejorative or marginal connotation within the discourse of medicine.

Of course, this effort to articulate equality through vocatives was a challenge even from the beginning. The workshop participants had all been asked to write their names on name cards for the sessions, and several biomedically trained doctors had included "Dr." in front of their names, while the traditional doctors had not, thereby establishing a division by virtue of education and training. Several biomedical doctors had written "Dr." plus their first name – and notably the women – perhaps in an effort to present themselves in a more accessible or informal manner to the healers. The male healers either wrote their full names or just their surnames on the name cards, and the female healers either wrote their full names or their first names. Over the course of the workshop, these name cards were corrected by adding "Dr." to healers' names, but this example does illustrate the challenge in reshaping structures and power relations that continued to be 'common sense' outside of the workshop setting.

4.2 Illegitimation

Next, I turn to an analysis of *illegitimation* practices that took place when the doctors interacted during the workshops. First, I demonstrate that discursive practices such as the vocative use of 'doctor' that I just discussed was used, despite their best efforts, only for the biomedical doctors, which ran counter to the egalitarian ideology previously espoused. I also present an example of conversational inquality in terms of how the traditional doctors responded to being accorded knowledge they identified as *uchawi* ('witchcraft') rather than their field of expertise, *uganga* ('healing').

Vocatives are an interesting site for the study of conversational inequality, as they are an ideologically relevant discourse structure that creates meaning in interaction (Van Dijk 1998). Other researchers have demonstrated how vocatives contribute to controlling who starts and ends an exchange, who interrupts, and who gets to raise a new topic. Power and solidarity are contextualized with vocative use, as speakers can adjust their social distance and deference or relative authority through their vocatives, in addition to other linguistic forms (Axelson 2007; Jaworski & Galasinkski 2000). Because the workshop facilitators had established a 'new norm' through their demytholozing narratives and their insistence on treating the participants with mutual respect, this new context (or discourse) becomes the point from which to analyze the vocative use.

4.2.1 Vocatives and illegitimated identities

One example of the use of *Dakta* for the biomedical doctors came in groupwork, when the participants were asked to write answers to the following questions on a poster-sized sheet of paper. This was a common practice at this workshop (and in many others I have observed), and was a form of demonstrating understanding of the ideas presented thus far. In one group I observed, the group was working together to answer a question about what they had collaborated on successfully so far, and they were negotiating what to include. One biomedical doctor, Veronica (who had identified herself as "Dr. Veronica" on her name card), was the person writing on the paper, and she was taking input from everyone. The other participants were all healers. Veronica was reading aloud as she wrote in line 1. In search of more items to add to

their list of accomplishments, Omary and Fatima then repeated the answer, and then Amina, another healer, used a vocative to draw attention to the fact that Veronica had been involved in the collaborations and had firsthand experience witnessing the success of their educational outreach. In using the address term in line 4, Amina simultaneously praises her biomedical colleague for her participation in the collaborative work and highlights the inequality between healers and doctors by remarking on the fact that 'even a doctor' has taken the time to be there to see such activities take place.

Extract 3

1	Vic(MD):	Kutoa elimu na,
2	Omar(H):	Na kutoa elimu na,
3	Fati(H):	>Elimu tumetoa.<
4	Amin(H):	Tumezitoa. Si hata **Dakta** unajua.

1	Vic(MD):	To offer education and,
2	Omar(H):	And to offer education and,
3	Fati(H):	>We've offered education.<
4	Amin(H):	We have offered it. **Doctor,** even you know (as you've seen it yourself).

The next example arose in a discussion about how to do a referral to a medical clinic. The system of referrals by healers was in itself an innovative practice that TAWG had embarked upon that made it possible for them to send patients to clinics operated by biomedical doctors. Though this referral system had been in place for many years, it was still new to many of the participants, which of course pointed to the need for the workshop. Referrals are not possible the other way around; there is no system for biomedical doctors to refer patients to healers. Shedenko, a healer, wanted to know how to ensure that any patients he referred to a clinic or hospital would be treated as if they had already seen a doctor, rather than as brand new patients who would then be placed at the end of a long queue. Dr. Saba asked the others to respond to his question, and though he was apparently unaware of it at the time, he used "Dakta" only for the biomedical doctors in the room in spite of his own stance as the facilitator towards establishing egalitarian address forms. See below for examples with address forms bolded. In (4), Dr. Saba calls on a biomedical doctor using "Dr." and his surname, a typical address form for biomedical doctors, to assuage Shedenko's concerns.

Extract 4

1	Dr. Saba:	Huyu alimtoa mganga wa jadi (.) hebu tumpeleka kwa daktari wanasemaje?
2		(0.5)
3		**Dakta Daffa** unasemaje?

4 Daf(MD): Mimi kwanza nashukuru kwamba ((talk omitted)

1 Dr. Saba: Anyone who taken someone from a healer to a doctor (.) what do you say?
2 (0.5)
3 **Dr. Daffa**, what do you say?

4 Daf(MD): First let me say I'm thankful that ((talk omitted))

After explaining at some length that he had not yet received a referral from a healer himself, Daffa asserted that he did not think it would be a problem to handle referrals from healers such as Shedenko. Dr. Saba then called on one of his colleagues by referring her to as "Dr. Tunu,"which made use of her first name. Like Veronica, Tunu also had self-identified as "Dr. Tunu" on her name card and was generally referred to as such by the group.

Extract 5

1 Daf(MD): Mi nadhani hilo halina akazungumzia zaidi.

2 Dr. Saba: **Dakta Tunu** (.) unasemaje?

1 Daf(MD): I think there's nothing more to say about this issue.

2 Dr. Saba: **Dr. Tunu** (.) what do you think?

In the same session, Dr. Saba then called on a healer, Hamisi Omary, using his first name, which is a fairly casual/informal choice. Omary had self-identified on his name card with his first and last names, and he was generally referred to as "Omary" in the group, so the use of "Hamisi" was somewhat unusual. Dr. Saba was slightly older than Omary, which may have justified his use of Omary's first name.

Extract 6

1 Dr. Saba: Ehe. Hebu tufafanulie **Hamisi.**

1 Dr. Saba: Yes. Then let's follow with **Hamisi.**

The final example of vocatives in (7) illustrates the endearing use of *babu* (lit. 'grandfather') as a vocative, which is a common way to respectfully (and affectionately) address someone who is significantly younger than oneself. Age-conscious address forms are common in Tanzania, where generational difference generally merits distinctions in greeting forms and other aspects of politeness, including whether one sits or stands and who serves whom a cup of tea. Here, Dr. Saba (who is in his mid 40s) asks Shedenko, who is in his late twenties, what he has to say about doing referrals as a healer.

Extract 7

1	Dr. Saba:	Ehe, **babu** unasemaje?
2	Shed(H):	Labda mimi nimsaidie daktari wenzangu hapa kwamba bahati mbaya hajawahi
3		kutoa rufaa,

1	Dr. Saba:	Yes, **grandfather,** what do you say?
2	Shed(H):	Maybe I can help my fellow doctors here who unfortunately haven't done a
3		referral,

Shedenko refers to the other healers at the workshop as 'fellow doctors' (line 2), thereby authorizing them, and himself, as on par with the biomedical doctors. However, it is questionable to what degree this authorization can come from a healer, rather than from someone already in a position of power, such as Dr. Saba. Moreover, the fact that the biomedical doctors regularly distinguished themselves from their healer colleagues by exclusionary use of the address term "Dr." indicates that all of the efforts of TAWG to level the playing field had little impact.

4.2.2 Conflation of waganga *('healers') with* wachawi *('witchdoctors')*

The final set of examples extends my examination of vocatives to the issues of which participants were seen as having specific sets of knowledge and how they responded to being positioned accordingly. The example came during a discussion of the differences between *wachawi* ('witchdoctors') and *waganga* ('indigenous healers') that the facilitators had raised in an effort to guide the participants to see more common ground between *waganga* and biomedical doctors. The logic seemed to be that through distinguishing both kinds of doctors as "not witchdoctors," an equivalency would be established. Nevertheless, as the conversation revealed, the biomedical doctors, and even the facilitator, engaged in discursive actions that portray the traditional doctors as equivalent to witchdoctors.

The first example comes from a conversation that began when a question was posed by Ngereza, a biomedical nurse, who was asking about the rather unusual idea of *kuruka ungo*, a type of magic often attributed to the Tanga region that allows people to travel through the air without using any devices other than their own bodies (McMillen 2008b). *Kuruka ungo* is not a practice that healers would generally ascribe to, particularly the set of healers at the workshop who were all dedicated to creating stronger bonds with their biomedical colleagues. Ngereza expressed curiosity about the practice, and many of the traditional healers in the room responded that it does exist.

Extract 8

1	Nge(MD):	Katika mazungumzo kwamba mtu akitumia ungo kwa kusafiria ni kosa la jinai.
2		Je (.) kweli kitu unakisikia kweli kipo?
3	Many(H):	Kipo.
4	Dr. Saba:	Mimi siwezi kulijibu hilo.

5 Tunu(MD): Maana hapa tunao waganga sasa.

1 Nge(MD): I've heard that if a person travels by witchcraft magic, then it's a mortal crime.
2 Is it true that this kind of travel exists?

3 Many(H): It exists.

4 Dr. Saba: I can't answer that.

5 Tunu(MD): This means we have healers in here.

Dr. Saba remained neutral toward the topic, leaving the discussion up to the participants entirely to take stances on. However, Tunu, a biomedical doctor, responded by exclaiming that 'we have *waganga* in here,' which conflated the healers with witchdoctors and thereby illegitimated them. As *waganga*, the healers were strongly identified as people who worked to treat the sick, and their very presence at the workshop and over the three year period of collaboration meant that they wanted to be taken seriously. Though she may have meant it in a friendly way, Tunu's mention of *waganga* after a question about witchcraft and challenged all of the authorization that TAWG and Dr. Saba had engaged in, and many efforts by healers to participate in acts of authorization themselves.

After some joking around, the conversation continued, and one of the biomedical doctors, Kingazi, nominated Omary (a healer) to contribute to the conversation about *kuruka ungo*, calling him "Bwana Omary" ('Mr. Omary') rather than "Dakta." Dr. Saba used the vocative *Sheikh* in reference to Omary's Muslim affiliation (which Dr. Saba shared), and as a whimsical reference to Omary's nomination by others as someone who would be in a position of knowledge. Omary was probably also chosen because he liked to talk. The humor did not get taken up, however, as Omary expressed disdain for the question and for the way his nomination to answer it positioned him as a witchdoctor (*mchawi)* or as someone who practices magic rather than healing. Though a tension had been building because the healers were not getting the respect they deserved for some time, this was the first moment when a healer vocalized the inequity that many had been experiencing.

Extract 9

1 King(MD): Bwana Omary.

2 Dr. Saba: Sheikh Omary, eti teknolojia hii ipo?

3 Omar(H): >Sitaweza kulijibu.<

4 Dr. Saba: Eh?

5 Omar(H): Hapo tumechanganya vitu viwili. (.) Uganga na uchawi.

6 Dr. Saba: Ah.

7 Omar(H): Sasa sisi hapa wote ni hapa sidhani kama kuna barua iliyoitwa mchawi. (.)
8 Imeitwa mganga.

9	Dr. Saba:	Ehe.

1	King(MD):	Mr. Omary.
2	Dr. Saba:	Sheikh Omary. Does the technology exist?
3	Omar(H):	>I can't answer that.<
4	Dr. Saba:	What?
5	Omar(H):	Here we have confused two things. (.) Healing and witchcraft.
6	Dr. Saba:	Oh.
7 8	Omar(H):	Now of all of us here I don't think there was a letter that invited a witchdoctor. (.) The letter invited indigenous doctor(s).
9	Dr Saba:	Uh huh.

After being nominated by biomedical doctor Kingazi, Omary responded similarly to Dr. Saba (in Extract 8) by explaining that he too did not have knowledge about such topics. Dr. Saba pushed him on it a bit, assuming that he must know about the practice of magical flying even if he himself did not believe in it or practice it. Nevertheless, in line 5, Omary attempts to authorize healing by distinguishing it from witchcraft, and by labeling all of the previous actions as "confusing" the two. In lines 7-8, he then underscores his legitimacy as a healer and as someone who has a rightful place amongst other doctors, biomedical and otherwise. Once again, however, it is doubtful that a healer can authorize his own legitimacy, even in a context where a rhetoric of equality has been put into place. Dr. Saba followed this point by taking a minimalist and neutral stance toward Omary's point, and then changed the topic after a moment of awkward silence.

5. Discussion

Through these few examples, I hope to have provided a glimpse of the efforts by an NGO that espoused a strong interest and which aimed to implement policies that embraced traditional medicine as a crucial part of the Tanzanian health system. It was clear from the beginning that the healers did not enter the relationship in the workshop from an equal starting point. Of course, this was the context that TAWG was seeking to change through bringing the two sets of doctors together and creating collaborative partnerships. Much needs to be praised about what TAWG is doing, as they are an NGO that is at the cutting edge of public health education and professional training. They are the only Tanzanian NGO to overtly embrace indigenous knowledge and to promote the value of traditional doctors alongside biomedical doctors. In fact, as the doctors' groupwork revealed, the biomedical doctors were quite interested in developing more mutually beneficial, and mutually respectful healthcare practices. For example, in response to the question of "What is the government's responsibility in the delivery of health services to the public?", one of the answers written by an intercultural teams of doctors was that they wanted the government to recognize the value of healing, to register healers, and to create a referral system that not only

allowed healers to send their patients to clinics and hospitals, but also for biomedical staff to send their patients to healers.

In official moments in the workshop such as these, biomedical doctors shared the view that healers deserved more respect and inclusion, and that they recognized their key role in helping them to earn more legitimacy in the eyes of the public and the government. The discussions often centered on raising awareness and working together as a means of enhancing their legitimacy. Nevertheless, through my close examination of the conversational and interactional practices in the workshop sponsored by TAWG, it seems clear that more reflective practices are still needed if meaningful inclusion is going to be achieved within workshops such as the ones studied here. In Laclau and Mouffe's terms, though official ideologies about equality are increasingly present in discourses of health and healing, these discourses remain resistant to indigenous healers in actual practice, leaving them outside the official discourse of legitimacy.

6. Conclusion

Discursive approaches to policy and practice offer a promising framework for identifying ideologies and practices, and for comparing the two. This idea is useful for a range of applied linguistics projects, from the worlds of public health to formal education. Just as researchers in educational linguistics have found troubling policy/practice gaps related to the equitable treatment of girls (AAUW 1992; Jule, 2004), minorities (Cazden 2001; Michaels 1981), and second language learners (Kanno & Harklau 2012; *Lau v. Nichols 1974*), this study has shown that despite their best intentions to produce more equality, educators and participants alike are complicit in perpetuating inequality through discourse.

As institutions such as NGOs attempt to find ways to redress inequalitites and to put policies of mutual respect and inclusion into practice, it is important to examine whether and to what degree their goals are being met. We can also think of the gap as one between rhetoric and reality. Oftentimes, rhetoric and policy is egalitarian but discursive practices in real world contexts demonstrate illegitimation. As in many applied linguistics contexts, it is essential to recurrently assess and reflect upon professional practice with regard to the rhetoric of policy, and to look at practice as a source of evidence of success— or failure – with regard to that policy.

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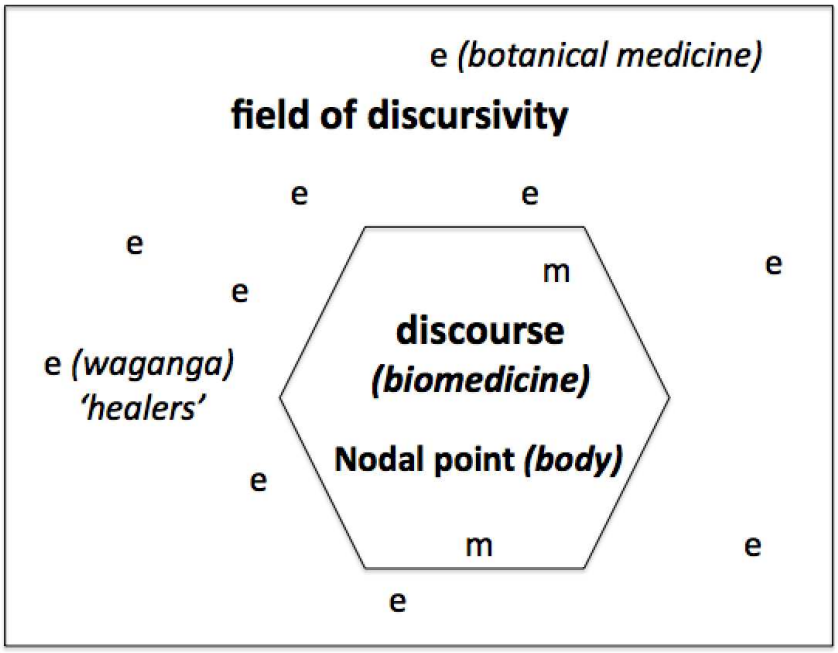

Figure 1. An illustration of Laclau and Mouffe's theory of discourse ('e'= element; 'm' = moment)

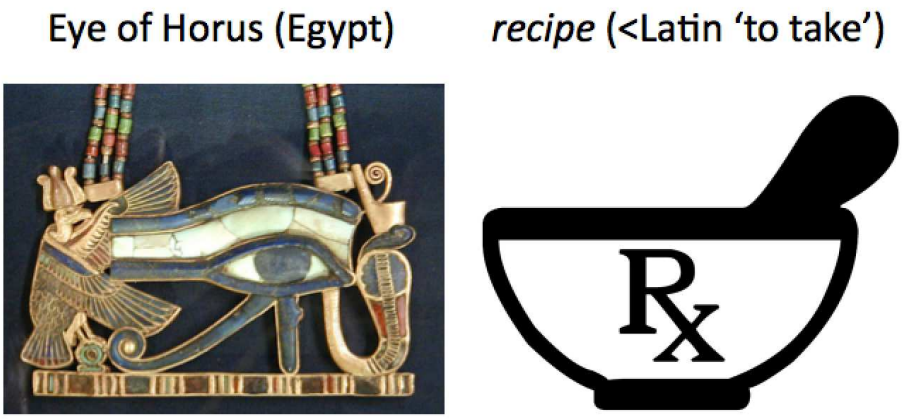

Figure 2. The Eye of Horus compared to the Rx symbol in biomedicine. Copyright free images courtesy of wikicommons.