Talking the illness
Swahili for medical aid and cooperation in Turin

Graziella Acquaviva and Mauro Tosco

This article presents and discusses the results of a pilot course aiming at teaching Swahili grammar and lexicon as well as cultural awareness in the field of health to a group of medical staff doing voluntary work in medical cooperation in East Africa. The different conceptions of illness and cure in traditional African and allopathic (Western) medicine are analyzed and discussed (sections 2 and 3). Notwithstanding the government policies advocating a better integration between African traditional medicine and biomedicine, true mutual understanding and communication on the field keep being a real challenge, and special attention was therefore given to the communication between doctor and patient. The use of Swahili in patient reports (section 4) and a modicum of language knowledge on the part of the volunteers can make a difference if coupled with some awareness of local cultures. As an output to the course (section 5), four bilingual English-Swahili patient reports were produced (personal and family’s physiological and patient’s pathological report, as well as a specialized patient report for language and communication disorders). They have, albeit partially, been tested on the field (section 6).

1. Preliminaries: who, what, where, when, and why

The article reports on the results of a pilot course in Swahili language and culture aimed at medical staff belonging to Piedmontese NGO’s and operating in East Africa. The pilot course was carried out in October - December 2016 in Turin. One of the authors (GA) was the teacher.

As the project was devoted to personnel active in medical cooperation, the actual course was preceded by a series of meetings and interviews with medics and paramedics who had long been

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1 Preliminary results were discussed at the XIV International Conference of Africanists: “Africa and Africans in national, regional and global dimensions”, Moscow, October 17-20, 2017. We want to thank the conference organizers and all the attendees for their precious help, criticisms, and remarks. This study was further presented on 21 May, 2018 to the “Unito-Africa” Conference at the University of Turin, and on 8 June, 2018 in Turin, at the workshop entitled "Frontier Semiotics" within the project “Education for Citizenship and to Global Health”, AID no. 011369) supported by the Italian Cooperation and Development Agency. Of course, all errors and omissions are our own only.

As per Italian academic regulations, the authors declare that Graziella Acquaviva is the author of sections 1, 2, 3, 4 and 5, and Mauro Tosco of section 6.
active in voluntary medical aid in rural areas of East Africa – and most specifically in Kenya and Tanzania.

The project *Talking the Illness* (It. “Parlare la malattia”) was designed and developed in collaboration with the Piedmontese Centre for African Studies (It. “Centro Piemontese di Studi Africani”)⁴ and was first presented in April 2016. It was approved by the regional Cooperation Medical Board (It. “Tavolo Sanitario della Cooperazione”), a consortium made up by the Piedmontese NGOs operating in the field of health cooperation and spearheaded by CCM (Italian: “Comitato Collaborazione Medica”), a Piedmont-based ONG established in 1968 in Turin and which is active in different aspects of medical aid (participation of medical personnel on the field; rehabilitation and enhancement of infrastructures; delivery of medicinal products and surgical instruments; personnel training in collaboration with local governments).

The course took place between October and December 2016 at the Piedmontese Centre for African Studies and consisted of 12 lessons, each one 3-hours long. The medium was Italian.

Attendees were a limited number of medical doctors, speech therapists, paramedics and students in medical anthropology; apart from the latter, they work in different hospitals in the Turin area and doing voluntary work with NGO’s based in Piedmont and operating in East Africa (mainly in Kenya). Voluntary is the keyword here: the attendees are regular employees of the Regional Health Service and take leave in order to volunteer in medical aid in non-governmental hospitals and dispensaries, often managed by different Christian denominations and with no help or assistance by the national health service. The volunteers engage usually in short periods of voluntary fieldwork; this circumstance limits the possibility of learning local languages and cultures. Still, all of them had a previous knowledge of basics of Swahili, learned either in the field or at the University of Turin (where Swahili is taught since 2010).³

At a preliminary meeting with all the participants, the attendees shared their own individual experience and expressed their expectations.

The meetings with the Cooperation Medical Board and the attendees helped to define the following course topics:

- the perception of illness, both from an allopathic (Western; imported) and traditional (local) perspective and the ensuing clash;

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³ The only other university in Italy where Swahili is taught being the University of Naples “L’Orientale” (formerly the “Oriental Institute”).
• an introduction to Swahili from a language-in-use perspective: greetings; overview of grammar (noun classes, word and sentence structure); specialized vocabulary in order to elicit the patients’ medical history cards, especially in the perspective of
• fostering new communicative skills, based on mutual knowledge and trust, between Western doctors/paramedics and the patients.

2. The perception of illness: Western and African approaches

The Swahili word for medicine is dawa, a loan from Arabic and a term boasting a wide range of meanings. When used in relation to healing it can refer to all kinds of actions, words or curses that can be obtained from medical specialists. The effect of dawa is not exclusively positive, as it can also be used as an agent to cause harm (dawa mbaya “bad medicine”; Larson 2008: 23). Healers use herbal medicine (mitishamba “wild herbs or plants”) for the treatment of chronic disease (Nsimba and Kayombo 2008: 319). Sometimes treatment with plants can be complemented by a ritual evocation (kubariki “to bless”) through the healers “powerful hands” (nguvu ya mikono) (Langwick 2011: 79; Feierman 1981: 357). On the Swahili coast and islands, where the majority of people are Muslims, healers write charms on clothes to be worn by the patient, recite religious texts and/or read special verses related to healing to the patient. The base for these is always the Qur’an and the Qur’an verses are essential for the dawa ya suna (“medicine of good tradition”; Larson 2008: 12).

This shows how much the Western and the traditional African approaches to illness (and cure) differ, and why they have long been seen as irremediably conflicting. Basically, two radically views of illness and remedy are at stake:
• allopathic medicine, or biomedicine, tends to understand diseases as a form of biological malfunctioning, with ill-health manifesting in chemical, anatomical or physiological changes (Ross 2008: 16);
• on the contrary, African traditional medicine refers to health practices, knowledge, and beliefs incorporating plant/animal/mineral-based medicines, spiritual therapies and manual techniques applied to diagnose and prevent illnesses (Feierman 1985: 110).

Although some scholars view the coordination between traditional African medicine and Western biomedicine as still in its infancy in most African countries (Gessler et al. 1995), it is apparent that the use of traditional medicine has received renewed attention due to epidemics such as HIV/AIDS, malaria and tuberculosis (Nsimba and Kayombo 2008: 319).
In the last decades, traditional medicine policies have been adopted in many member states of WHO (the World Health Organization), Tanzania included (Akerele 1991; Langwick 2011: 58) and a more nuanced approach has seen the light, and some kind of dialogue and coordination are being put in place. WHO reconsidered traditional medical practices as early as 1978 (WHO1978: 8, 29, 38; WHO 2000a, 2000b), and the collaboration between traditional and biomedical health practitioners was legally accommodated in Tanzania in the same year (Akerele 1991; Langwick 2011: 58; Ahlberg 2017: 1-4): traditional medicine received legal status in the Medical Practitioners and Dentist Ordinance Act (caption 409, section 37) and the Pharmaceutical and Poisons Act 1978, which stipulates substances and their use (Akerele 1991: 6).

Again at the end of the 1970s, the Traditional Medicines and Drugs Research Centre of the Kenya Medical Research Institute had been able to establish some form of dialogue with the traditional healers on an interactive basis (Aluoch et al. 1991: 9).

In 2002, the Muhimbili University College of Health Sciences (MUCHS) of Dar es Salaam established an Institute of Traditional Medicine whose focus was researching and developing standardised quality herbal medicines (http://www.muchs.ac.tz/ITM1/aboutus.htm).

On the other hand, efforts to recognize and foster the use of traditional medicine have long been and still are jeopardized by mutual distrust as well as by the difficulties in many African countries in regulating such practices (Mwambo et al. 2007). Again in 2002, highlighting again the complexity of the situation, herbalists (Sw. mganga, mganga wa kiasili, etc.) were allowed to practice and distribute their remedies in standard (allopathic) facilities (Traditional Medicine Act) in Kenya, but the law has since been stricken due to the opposition of the allopathic medical personnel (Amutabi 2008).

Although many people use biomedical treatments, especially in urban areas, the majority of people use traditional medicine (Makunnah and Mshiu 1991: 85). The usage of and/or the compliance with therapeutic health care is influenced by several factors:

- the availability of health service;
- the relative and absolute costs;
- the patient’s classification of diseases and her/his perception of quality cares: hospitals, modern medical practice and the doctor-patient relationship.

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4 Cf. also Acquaviva’s article “Healing and Spirituality in Tanzania: the mganga figure between literature, myths and beliefs” in this issue.
In comparison to the allopathic medical doctor, the local healer and medicine-man is part of the culture and operates within a known cultural environment, with its own definite known cultural norms, values and beliefs (Waane 1991: 212).

3. The semantics of body and illness and disease

If considered at different levels, the disease is a symbolic network conditioned by the structural construct in which it is manifested or is perceived.

To consider medicine as a hermeneutic process and illness as a symbolic and an organic construct involves the need to go beyond the linguistic level, where the two codes are different in lexicon and semantics and cannot be superimposed: it becomes necessary to reach a metalinguistic level where specific terms correspond and depend on the speaker and his or her own culture. This level of cultural communication highlights how behind every concept and expression there is a specific semantic system (Mazzetti 2005; Fantauzzi 2010).

A semantic analysis of Swahili idioms shows that body parts and bodily fluids (e.g., kichwa “head”, mkono “hand/arm, moyo “heart”, jicho “eye”) are metaphorically used as a source domain for more abstract and/or cultural concepts and meanings, such as character traits, feelings, emotional status and so on.

Random examples of nontransparent idioms with body parts include:

- kichwamaji (kichwa “head” + maji “water”) ‘silly person’ (lit. “water(ly) head”; Kraska-Szlenk 2014: 63);
- usimkanie vyanda vitano (a Swahili proverb; lit. “Do not think he does not have five fingers”) ‘Do not think he is not able to take what does not belong to him’ (Knappert 1997: 11);

In particular, mkono “hand/arm” (like many other languages in the area, Swahili uses here the same word for both referents) conceptualizes a man’s participation in social life. According to Talento (2014), a physical participation is suggested by means of expressions like: mkono kwa mkono → ‘hand in hand’; mkono mmoja haulei mwana → ‘A single hand cannot nurse a child’; kuunga mkono (lit. ‘to join one’s hand’) “Many hands operate for the society and the community” (Talento 2014: 270). Mkono is found in many other idioms, such as:

- mkono wa birika (mkono “hand/arm” – like many other languages in the area, Swahili uses here a single word + birika “kettle”) → ‘miser’;
- mkono mtupu haulambwi (a Swahili proverb; lit. “An empty hand is not licked”) ‘A poor man is not served’ (Knappert 1997: 98).

According to Kraska-Szlenk (2014: 55-57), moyo ‘heart’ is conceived as a container in which all kinds of emotions may be kept and which may be full or empty, closed or open:
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- majonzi aliyo kuwa nayo moyoni “grief that he/she had in his/her heart”
- alianza kumfunuliza moyo wake “he/she started to open his/her heart to him/her”
- moyo wake ulija hisani “his/her heart was filled with kindness”
- utazame moyo ulivyongua “look how the heart is burning”
- wanatuzidi silaha lakini hawatuzidi moyo “they beat us as to weapons, but they do not beat us to the heart/courage”
- moyo wangu huwa haupendi kuona watu wanasumbuka “my heart does not like to see worried people”

Sometimes moyo gets associated with jicho ‘eye’ as a locus of love, as in the verses jicho ndilo la awali, mashaka kukuletea, moyo ukawa wa pilii matatani kukutia “the eye was the first to give you trouble and the heart was the second to entangle you” (Knappert 1972: 157), while in its turn jicho is also used for “a dear person”: huyu ni jicho langu lit. ‘he/she is my eye’ (Kraska-Szlenk 2014: 57).

If the physical body is conceived as a ‘locus’, a sacred place through which one expresses oneself both from a linguistic and an emotional point of view, it is equally true that the illness/disease - that threatens and often destroys it - becomes unspeakable or manifested through the use of linguistic expressions designed to generalize rather than individualize the illness/disease.

As a consequence, the popular and everyday use of words and concepts referring to health is greatly at variance with scientific terminology. Let’s take two examples. When talking of “fever”, the word homa is in general use. Homa, a loan from Arabic, is mentioned as a symptom of almost every illness but it is also an illness itself:

- homa kali, homa ya kuchemka (‘hot fever’, ‘boiling fever’): “high fever”;
- homa ya kawaida “ordinary fever”;
- homa ya vidonda “fever from ulcers” (kidonda, Pl. vidonda). Some scholars translate vidonda as “boils”;
- homa za matatizo “fever of problems” (matatizo; from hard work, inabilitiy to sleep because of mosquitoes, hunger or sorcery);
- homa za vipindi “fever of periods” (vipindi: different periods of time; joints of body): intermittent fevers every 48 hours, or seasonal fevers, or associated with joint pain;
- severe fevers are referred to as “out-of-the-ordinary fevers” (homa zisizo za kawaida) or “fevers which do not respond to hospital treatment” (homa zisizokubali tiba za hospitali; Winch et al. 1996: 1061).

In Swahili there is no indigenous specific term for “malaria” and the word homa is used in rural regions or by people with a low level of formal education. Otherwise the loanword malaria or mleria is used:

- homa ya malaria “malaria fever”;
- malaria ya kawaida is the equivalent of “clinical malaria” in Western medicine;
• *malaria ya kichwa* (*kichwa*, Pl. *vichwa* “head”) “cerebral malaria”. Locally, this form of malaria is separated into *Malaria ya kuanguka* (the verb *kuanguka* means “to fall”) which causes convulsions, and *malaria ya kichaa* (*kichaa*, Pl. *vichaa* “madness”) which only causes confusion;

• *malaria ya tumbo* (*tumbo*, Pl. *matumbo* “stomach, abdomen”) is an “Abdominal malaria” (Gessler et al. 1995: 124 – 125);

• *ndege* or *dege* “convulsions”. The word *ndege* literally means “bird-bird”, and it is used as a translation for febrile convulsions in children and is recognized by the sudden onset of severe fever, trembling and/or stiffness of the limbs, frothing at the mouth, babbling incomprehensibly. This illness is so feared that people use a euphemism for it: *ugonjwa wa kitoto* (“childhood illness”). In Kenya, convulsions in children are very often attributed by mothers to supernatural forces and therefore require a traditional treatment. The belief in the supernatural causation of the illness contributes to a notion of defence mechanism referred to as *kinga* (“protection”). The individual can protect him/herself by wearing *hirizi* (“amulets”) prepared by traditional healers (Gessler et al. 1995: 122; Winch et al. 1996: 1061-1062).

When taboo gets associated with illness, metaphors as always abound. Swahili has *UKIMWI (Ukosefu wa Kinga Mwilini)* for “AIDS” and *VVU (Virusi vya Ukimwi, Virusi vinavyoleta Ukimwi)* for “HIV”. In everyday usage, where the sexual organs are called *sehemu za siri* (“secret/confidential parts”), anything related to sex is likewise perceived as “secret”, and sexually transmitted diseases are *magonjwa wa siri* “secret diseases” (Mutembei 2015: 196). Metaphors likely to be used in colloquial Swahili include:

• *kale ka Mdudu* (a kind of bug?; non-standard/local) “HIV”;

• *ugonjwa wa kisasa* (“modern disease”) “AIDS” (Kirkeby 2000: 29);

• *Juliana* (name of a brand of cloth commonly smuggled between Uganda and Tanzania at the time the HIV epidemic began) “HIV”;

• *silimu.slim* (from Eng. *slim*) “AIDS”;

• *Dubwana* (“a huge nameless effigy that kills indiscriminately;” Mutembei 2015: 197) “AIDS”.

### 4. The situation in the field/1: what medical personnel find and need

As anticipated in section 1, in order to understand what the medical personnel needed, we interviewed around twenty medical doctors and/or paramedics. During a preliminary meeting, the attendees recalled their experience as voluntary workers in Africa: everybody had deeply enjoyed and appreciated the new impetus given to their profession, too often stifled in Italy by the usual red tape. At the same time, they stressed the problems of operating in areas about which only very superficial previous knowledge of the local language and culture had been made available to them. Their experience highlighted the eminent role of communication in health services: language
barriers negatively affect not just the access and use of services, but also the quality of health care and its results, the patient’s satisfaction, and jeopardize the prevention campaigns in rural and peripheral areas.

Our attendees, as anticipated in section 1, rotate their voluntary work in non-government health facilities: in these small hospitals are usually manned by a resident doctor (either a local or a foreigner) and a local Clinical Officer (CO). Paramedical staff vary in number and are usually trained locally by the missions or international NGOs. They may perform different duties according to the necessities, from acting as an operating room nurse or as an obstetrician. It is not unusual that both the resident and the voluntary doctors, who can be a surgeon or as an ENT specialist in Europe, may also happen to work as a gynaecologist, an infectious disease doctor or an ultrasound technician.

What follows is a selection of experiences collected at the Cooperation Medical Board and may help elucidate the issues at hand:

“An elder (maybe 70 y.o.; no identity card) is admitted with high fever and strong abdominal pain. On the basis of the available data, the Clinical Officer prescribes hospitalization and an abdominal ultrasound exam. The latter reveals a hernia as well as many adhesions. During the medical examination the local doctor and me had already noticed that the patient had several keloidal scars on his abdomen, and we even thought that he had already undergone surgery. Abdominal palpation clearly revealed local inflammation and therefore hard to the touch.

I decided it was better to ask for more to the person accompanying the patient. After some resistance, the patient finally admitted having undergone traditional healing practices in the form of repeated burning of the groin area.

At the beginning we had selected our course of action on the basis of objective data; later, the clinical history made us choose a different treatment (anti-inflammatory drugs, pain-killers, and antibiotics, followed by surgery). Emergency surgery in the absence of such an information and on the basis of the Patient Report only could have resulted in the patient’s death on the operating table”.

(B. S.; August 2014, Sololo, Kenya).

“The patient arrives at the OPD [: Out-Patient-Dept.]. She has strong pain, fever and general debilitation. She has done a 12-hours walk from her village. After admission, the CO prescribes malaria and HIV tests. The woman is found positive at the malaria test and gets hospitalized for the required therapy. Two days later I was doing rounds together

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5 For privacy reasons, the first letters of the names only are provided.
6 This and the following reports were originally collected in Italian and have been translated by the article’s authors.
with the CO, who speaks Swahili. Thanks to pointed questions, I find out that the patient is two months pregnant. I immediately have her transferred to the maternity ward and prescribe re-dosing her therapy and fetal monitoring ... Well, we really risked a lot because the pregnancy was not mentioned anywhere”.

(L. C.; Summer 2015, Mwika Health Center, Kenya)

“The patient arrives at the OPD claiming to suffer from acute abdominal pain and diarrhea – these are the only objective data. The Clinical Officer prescribes text for parasitosis and hospitalization. Since the afternoon of the hospitalization day the patient starts vomiting blood and pain continues. She repeatedly gets blood transfusion for three days. Her clinical situation later subsided, but we could never diagnose her due to the lack of adequate tools and the absence of the patient’s clinical history”.

(M. C.; April 2014, Itololo Hospital, Tanzania)

“The elderly woman comes to the OPD together with her daughter, who says that her mother has trouble swallowing and lost much weight lately. The CO prescribes hospitalization. She is tested for HIV, malaria and parasites with negative results. The next day during rounds I ask the CO to help me talk to the daughter, who could not speak English – the tests had been negative, and I had no patient’s history to start from. I therefore managed to realize that she was by now in a chronic condition. This was later confirmed by X-ray: this showed a tumor that was deviating the trachea. The woman was redirected to the Mbeya Referral Hospital, even though the situation was by now quite serious. Had we not been able to reconstruct, even partially, her clinical history, the woman would have probably died in our ward without even knowing the cause of her death”.

(A. F.; March 2013, Chimala Mission Hospital, Tanzania)

It is against the backdrop of histories like these that many course attendees stressed the need to get a better knowledge of Swahili grammar and lexicon in order to interact with patients.

5. The situation in the field/2: the (possible) role of Swahili in medical aid

Swahili is certainly the most “developed” African language. With “developed”, “Ausbauized” is meant here (Tosco 2008), in the sense of made fit to be used in a standardized variety (the Swahili sanifu) in a wide range of contexts and most specifically in administration, education and in principle any other modern fields. Still, the Swahili technical lexicon of health care is greatly lacking in both precision and uniformity. One example will be enough: Figure 1 shows one page of a bilingual Swahili-English booklet used for teaching hygienic basic procedures.
The “pathogenic microorganisms” which appear twice on p. 123 (and once again on p. 125) come to have three different Swahili renderings:
• *vijidudu vyenyе vimelea vyа magonjwa* (Marazzi 2007: 123), lit. ‘small insects which carry the parasites of disease’;
• *vimelea vingi vyа magonjwa* (Marazzi 2007: 123), lit. “many parasites of sickness”;
• *vijidudu vingi* (Marazzi 2007: 123), lit. “many small insects (i.e., germs)”

When a patient first enters a dispensary, he or she will find in the Out-Patient Department (OPD) a specialized health worker, the Clinical Officer (CO), whose task is to collect the patient’s data and his or her symptoms on a “Patient Report”. It is on the basis of the patient’s answers that the CO will decide whether the patient needs hospitalization and which medical tests he or she will undertake.

In East Africa, especially in the rural areas which are our concern here, most often the patient’s data, clinical history and symptoms are written down by the CO on a blank piece of paper and only in a few lucky occasions on a form, such as the one found in Warner (1992). The latter is an updated edition of *Where there is no doctor. A village health care handbook for Africa*, a handbook written for paramedics operating in rural and peripheral dispensaries but which could be useful for village people themselves. The first edition (1977) was translated into Swahili as *Mahali pasipo na daktari. Kitabu cha mafunzo ya afya vijijini* (first edition 1978, second edition 1984) and published in Tanzania with funding from Rotary International. Sadly, the Swahili text did not include any type of Patient Report. Nel 2007, the Italian “Comunità di Sant’Egidio” published in Tanzania *How’s Your Health? How To Help Yourself and Others Feel Well / Je! Waijua Afya yako? Jinsi ya Kuitunza Afya Yako na ya Wengine Ili Kujisikia Vizuri*, a bilingual English/Swahili handbook of hygiene written in layman’s terms and useful for disease prevention (cf. Fig. 1 above).
During the course the attendees were urged and helped by the teacher to devise and implement four bilingual English-Swahili report forms for collecting the patient’s data at the OPDs on the basis of those currently used in Turin hospitals; the first three are presented below and deal, respectively, with:
• the patient’s physiological history (Table 2),
• his or her family’s physiological history (Table 3), and
• the patient’s pathological history (Tables 4a, b, c).

Table 2. The Patient’s Physiological History
### Table 3. The Patient's Physiological Family History

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does/did anybody in your family suffer from heart diseases?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu mwingine wa familia ambaye anaumwa au aliumwa na mgonjwa ya moyo?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Did anybody die suddenly?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Je, mtu mwingine wa familia alikuwa kwa kifo cha ghasta?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Did anybody in your family have a myocardial infarction?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu wa familia aliyumwa mshuko wa moyo?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Does/did anybody in your family suffer from hypertension?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu wa familia ambaye anaumwa au aliumwa na shinikizo la damu liilopenda sana?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Does/did anybody in your family suffer from high cholesterol?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu mwingine wa familia anayepata au aliyepata tatizo la kolesteroli?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Does/did anybody in your family suffer from diabetes?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu mwingine wa familia anayumwa au aliyumwa na ugonjwa wa kisukari?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Does/did anybody in your family suffer from thyroid diseases?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu mwingine wa familia anayepata au aliyepata magonjwa wa kikoromeo?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Does/did anybody in your family suffer from lung diseases?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu mwingine wa familia anayumwa au aliyumwa na magonjwa wa mapafu?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Does/did anybody in your family suffer from neurological diseases?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu mwingine wa familia ambaye amepata au alipata magonjwa na nyuroloja?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Does/did anybody in your family suffer from cancer?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu mwingine wa familia anayumwa au aliyumwa na kana?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Does/did anybody in your family suffer from asthma?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu mwingine wa familia ambaye amepata au alipata pumu?</td>
<td>NDIO/SIO</td>
</tr>
<tr>
<td>Does/did anybody in your family suffer from allergies?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Yuko mtu mwingine wa familia anaye mzi wo kitu chochote?</td>
<td></td>
</tr>
</tbody>
</table>
Table 4a. The Patient's Pathological History (part 1)
<table>
<thead>
<tr>
<th>Question</th>
<th>Swahili</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you suffer from breathlessness?</td>
<td>Umepatwa/Ulipatwa mtweto?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Does the patient suffer from breathlessness?</td>
<td>Ameapatwa/Alipatwa mtweto?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>If “yes,” when?</td>
<td>Kama “adio”, imetokea lini?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Did you have a heart attack?</td>
<td>Umeumwa/Ulimwa mshtuko wa moyo?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Did the patient have a heart attack?</td>
<td>Ameumwa mshtuko wa moyo?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>When?</td>
<td>Lini?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Do you suffer from hypertension?</td>
<td>Unauumwa/Umeumwa na shinikizo la damu hilopanda sana?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Does the patient suffer from hypertension?</td>
<td>Ameumwawa/Aliumwa na shinikizo la damu hilopanda sana?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Do you take drugs?</td>
<td>Unatumia/Anatumia dawa?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Does the patient take drugs?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
<td></td>
</tr>
<tr>
<td>Do you suffer from diabetes?</td>
<td>Unauumwa na ugonjwa wa kisukari?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Does the patient suffer from diabetes?</td>
<td>Anaumwa na ugonjwa wa kisukari?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Do you take insulin?</td>
<td>Unatumia/Anatumia insulini?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Does the patient take insulin?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
<td></td>
</tr>
<tr>
<td>Which drugs do you take?</td>
<td>Unatumia/Anatumia dawa gani?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Which drugs does the patient take?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
<td></td>
</tr>
<tr>
<td>Do you have high cholesterol?</td>
<td>Umepata/Amepe tatazoo la kolesteroli?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Does the patient have high cholesterol?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
<td></td>
</tr>
<tr>
<td>Do you have leg ulcers?</td>
<td>Una/Ana vidouda mgunni?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Does the patient have leg ulcers?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
<td></td>
</tr>
<tr>
<td>Since when?</td>
<td>Tangu lini?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Do you suffer from bowel diseases?</td>
<td>Unauumwa/Anaumwa na magonjwa ya tumbo?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Does the patient suffer from bowel diseases?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
<td></td>
</tr>
<tr>
<td>Do you have dry heaving?</td>
<td>Unapatika/Anapatika?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
</tr>
<tr>
<td>Does the patient have dry heaving?</td>
<td>□ NDIO</td>
<td>□ SIO</td>
<td></td>
</tr>
</tbody>
</table>

Table 4b. The Patient’s Pathological History (part 2)
On the request of a speech therapist who was also a participant in the course, a further specialized patient report for language and communication problems was devised. The speech therapist had dealt with deaf and deaf-mute people in Uganda and Tanzania in previous medical cooperation stages, and she had noticed specific problems in dealing with her patients.

Actually, in many Sub-Saharan countries, deaf people tend to be marginalized and physically isolated by their family and the society at large. The perception of the deaf person’s condition changes according to the local culture, but in East Africa, and more specifically in Tanzania, it is

Table 4c. The Patient's Pathological History (part 3)
particularly negative and families isolate a deaf child (e.g., schooling is avoided), in order to avoid social stigma to the whole family. This is often linked to the idea that deafness and other pathologies are originated by witchcraft and spirit possession (Batamula and Pudans-Smith 2017: 24; Lane 2005: 298). Still, in the last decades groups and associations started to operate to change the social consciousness of these pathologies; among them:

- the TASLI (Tanzania Association of Sign Language Interpreters), established 2006 ‘as part of the implementation plan of resolution made by participants of the world Association of the Sign language interpreters (WASLI) meeting held in Cape town South Africa in 2005’
- the Association of Sign Language Interpreters Lake Zone, based in Bukoba, Tanzania;
- the Anglican Diocese of Ruaha (Iringa, Tanzania) founded in 2003 the Neema Craft centre, devoted to improve the life quality of people with disabilities and provide them with work opportunities and social integration.

Our Patient Report for Language and Communication Problems was created anew with a close eye to functional communication and communicative goals and following the guidelines for the evaluation of communication abilities (Beukelman 1991; Chilosi 2014). The overall goal was to help formulate patient-specific therapeutic pathways.

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7 https://envaya.org/TASLI/history
4 https://envaya.org/waka
10 https://www.neemacrafts.com/index.php
Table 5a. The Patient's Report for language and communication problems (part 1)
14. Did you go to the dispensary to check his/her weight and growth? Do you have a certificate? /
Mmekwenda dispensary kucheki uzito na ukuaji? Karatasi unayo? ............................................................

15. Child’s development tables / Chati za maendeleo ya mtoto
• When did the child start walking? During his/her first year? After his/her first year? /
Alianza kutembea limi? Wakati wa mwaka wa kwanza/ baada ya mwaka wa kwanza....
• When did the child start eating solid food (not just milk) /
Alianza limi kula chakula cha kawaida? (sio maziwa tu) Miezi
• When did the child start uttering his/her first words /
Alianza limi kutamka maneno ya kwanza?
• When did the child start making sounds or point to what he/she wanted /
Alianza limi kutoa sauti au kuonyesha/kupoint vitu alivyotaka

16. Did the child have childhood or other (malaria, fever, rubella, mumps...) diseases? /
Alipata magonjwa ya kitoto au mengine (malaria, homa, rubela, matubwitiswi...)?
• If yes, which one? When? Why? /
Kama ndio, ugonjwa gani? Lini? Kwanini?

17. Does or did the child suffer from / Sasa anaumuwa au aliumwa zamani na:
• Any kind of otitis? If yes, which one? When? Why? /
Magonjwa ya masikio? Kama ndio, nini? Lini? Kwa nini?
• Throat or neck diseases / Magonjwa ya koo/shingo?
• Eye diseases / Magonjwa ya macho?
• Nose diseases / Magonjwa ya pua?
• Dental diseases / Magonjwa ya meno?

18. Did the child take medicinal products? Which ones /
Mtoto alimeza dawa? Dawa gani?

B. Pathologic History / Historia ya patholojia
1. Why did you come here? Which problems Il binbo che problemi ha?
Kwa nini mmefika hapa? Mtoto ana tatizo gani? ...........................................................

2. Does anybody in his/her family have the same problem /
Yuko mtu mwingine kwenyewe familia anaye tatizo sawa sawa kama lake?

3. When did you realize that the child was in trouble /
Umegundua limi mtoto alipata shida?

4. Did you go to the hospital or the dispensary for this problem? What did the doctor say /
Mmeshaenda hospitalini au dispensary kwa shida hili? Daktari alisema nini?

5. Tell me please about the problems the child presents everyday /
Naomba unieleze shida gani mtoto hupata kila siku

Table 5b. The Patient’s Report for language and communication problems (part 2)
Table 5c. The Patient’s Report for language and communication problems (part 3)
6. Testing the results and a tentative conclusion

It must be admitted from the outset that only very limited testing on the field has been carried out. What is needed are reports as the following one, coming from L. G., a professional nurse who had already done voluntary work in Kenya and who followed the course before going back into the field:

“I reached the Sololo Mission Hospital in March 2017. I had already done voluntary work there in 2011, 2012 and 2014, and I knew the reception procedures at the local OPD: I therefore suggested to the resident doctor to use the physiological, pathological and family histories we had written down and translated into Swahili during the course in October-December 2016 (on the basis of the very reports used in the hospital I work at). The local medical doctor, a Burundi citizen who had done his medical studies in Italy, accepted my proposal [to test the new patient report sheets] and made available to the local Clinical Officer – who was very much resistant to change – a set of photocopies to be used at the OPD.

One day, a girl around 12 y.o. and various family members arrived in Sololo from Moyale (around 20 kms. far). She had acute pains in the pelvic region and could not urinate. She brought from Moyale an ecography but no medical report – the local doctor
had not been able to identify the material shown in the ecography. This girl was the first patient who was administered the patient report sheets. Thanks to her personal medical history we could diagnose a haematocolpos.\textsuperscript{11} We immediately performed bladder catheterization followed by surgery. Her clinical situation stabilized.

As long as I was in Sololo [approximately one month], the Clinical Officer used the new patient report sheets, sometimes not completely filled due to lack of data, but always accompanying the medical records.”

(L. C.; March 2017, Sololo, Kenya)

Obviously, much more feedback is needed.

How can rituals and practices in local healing, in case, be accommodated in the everyday life of a rural dispensary in East Africa? Are, e.g., ritual burnings and scars “wounds”? Is the medical volunteer expected to know and fully comprehend the different use and significance of the body across cultures? In these contexts, an interdisciplinary approach should take the centre of the stage and act as a glue between medical science and disease in its cultural dimension. The role of medical personnel in cooperation is currently being thoroughly reanalyzed and reconsidered thanks to the impact of the Global Health Education. In this paradigm, a multi- and transdisciplinary and plurimethodological approach is advocated in order to benefit from both human and social knowledges and natural and biomedical sciences.\textsuperscript{12}

The Turin course was just our first experiment in teaching an African language, a culture and what lies between them to medical personnel. It is an experiment to be hopefully repeated and improved in the future.

References


\textsuperscript{11} Blood pooling in the vagina.

\textsuperscript{12} Literature on global health education has been increasing in recent years; from an incredibly vast bibliography we mention here Adams 2016 and Sklar 2016 and, on Kenya in particular, Mayo 2014. Cf. also the webpage of the Global Health Education Consortium (http://www.who.int/workforcealliance/members_partners/member_list/ghec/en/) and, for Italy, the webpage of the RII SG (“Rete Italiana per l’Insegnamento della Salute Globale”; \textit{Italian Network for Global Health Education}; http://www.educationglobalhealth.eu/it/salute-globale/9-global-health/247-riisg-definizione-di-salute-globale).


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