Introduction

KAJUMBA

In August 2015, George went to meet a man named Kajumba[1] at his home, just off the Entebbe Road highway. Pastor Andrew had recommended that we meet him to learn something about the people who had stopped drinking through their involvement at his church, the Christian Glory Center, a large Pentecostal church near Kajumba's home. George had already tried to visit Kajumba three times at the church, but beyond a first introductory visit with Pastor Andrew, Kajumba had not yet kept an appointment. Now George was to meet him at his home. "You can't miss their house, it's the old one, from the 1960s," Pastor Andrew had instructed him. George had in fact seen that old house many times as he passed on this road, not knowing that it was Kajumba's. The house was a big one, and it was surrounded by a very large compound and shaded by palm and *mutuba* trees.

A girl collecting water at the family water tank directed George to the back of the compound, and George continued past the house down to the swampy area behind it. George had briefly met Kajumba only once before, and at first did not recognize his face. But when Kajumba stood up, his unusual height made him unmistakable. He was standing in front of one of the three rooms of the back boys' quarters, holding a hoe in his hands, a tin of bean seeds at his feet. His loose gray trousers were folded to the knee, and he was barefoot. Clearly wanting to get back to his planting, he asked George how long the interview would take. "I can only give you ten minutes today. I want those seeds to spend the night in this soil," he said, ushering George into his house.

In the first room there was a sofa set and George tried to sit down, but Kajumba passed through, calling George to continue to the next room. The other room had sofas too, but these looked newer. There was also an old computer monitor and keyboard, but no CPU. On the wall were pictures of Jesus and a placard reading "Jesus is the head of this family." Hanging on the wall there was also a portrait of

an old man of about sixty and framed photos of a formal *kwanjula* ceremony and wedding. The groom in both was Kajumba. After the formalities of greetings and consent forms, Kajumba began to tell his story.

"I am fifty-three years old. I come from the line of Ssekabaka Tembo," he started. "I don't know when my father settled here, but he originally came from Buddu. My father was Catholic and wanted me to become a priest, but he took me out of seminary because of my poor grades. After attending a different secondary school, I came back to the family home and got a job nearby at a garment factory. I was earning well, but then Idi Amin was overthrown, the company was looted, and I lost my job. After that, I started slowly to taste *waragi*, and it gradually developed into a habit. My mother had connected me to a job in a restaurant, right next to [the] Peacock Bar. I was working but also seriously drinking alcohol, feeling like a youth. I was always with a group, most of them are dead now. I usually left work at the restaurant at 8:00 p.m., sometimes later than that. Remember, I told you that opposite the restaurant was the Peacock Bar. What followed is obvious. But I was clean and knew how to make money. I woke up very early and worked. I took five years, seven years, ten years—drinking in a respectable way. But when I clocked twelve years, alcohol said, 'You are now ours!' And I began doubling the amount that I took.

"I began to be a *lujuuju*, someone people knew as a serious drinker. But I still had money. I was a good brickmaker and the money I made from the bricks I invested in tomatoes. We have a lot of water here, so I created an irrigation system so that I could harvest tomatoes in the dry season. I remember one time I had a big harvest, and I was the only one in the area who had tomatoes, but because I had started taking alcohol stupidly and there were no phones then, the buyers looked for me in bars.

"This was in the late 1980s and our main drinking spot was under an avocado tree, where you have seen a new factory being built. We had a group called *Basajjabatudde* (the men are seated). There was one in our group who worked in a cooperative society as a chief accountant. He was later fired because of his drinking. But at that time, he used to come with money and buy for the whole group which had about twenty members. Whether or not you had money, he bought for you. We had a ten-liter bottle which we would fill with waragi and place in the center of the table. Each could take as much as he wanted, and it would be refilled by that man many times.

"Over time, alcohol built a house on me, and I gradually failed to cultivate food. By the time of the first morning call to prayer at the mosque, I was already holding a *lubanto* bottle (250ml) of waragi in my hands. For a time that bottle could allow me to work, but over time I couldn't even raise up my head. Alcohol weakened my legs. I lost my appetite. And I totally stopped working.

"To get money to drink, I started selling things from the house. I was unmarried and living in the boys' quarters. Before I started drinking seriously, I used to select nice clothes, but eventually I sold all my clothes. I used to pray for sunshine so that I could wash and quickly dry the only shirt and trousers I had left. Then

I sold the beds, the cups. Eventually, even my fellow drinkers chased me away from their group because I stopped bathing and washing my clothes. By this stage, I couldn't bathe. When I tried to bathe the water on my body burned like chemicals."

"Did anyone ever counsel you during that time?" George asked.

"My family and neighbors talked to me about the problem. Even my fellow drinkers used to tell me, 'We all drink, but you have excelled on us.' They isolated me and made me sit on the ground. But with my stupidity and with Satan entering my brain, I didn't notice how bad things were.

"I wouldn't sleep until I had filled my bottle at the bar for the next morning. I would pay for it and put it on the table. By the time the Islamic call for prayer came at five in the morning, I was there knocking at the door. The bar owner would open the door, give me my bottle and three cigarettes, and go back to bed.

"Having sold off my bed and mattress, I was now just sleeping on old sacks. Eventually, my father locked the house because there wasn't anything left in it, and I was forced to sleep on a stack of bricks that I didn't have the firewood to burn. But truly, how could they let me sleep in the house? How could I fit in a family of the royal clan, me who looked like a mad person? My father refused to let me enter the house to eat, but even though my father refused, my mother would sneak food to me when she could."

"Now, I know you said that you don't have much time today. Let's talk about how you quit," George interjected, worried for Kajumba's beans and the fading sun.

"It was June 1999," Kajumba continued. "There was a crusade at the playing field and people singing a song in Swahili, '*Wa milele wa milele. Mungu wabaraka ni Yesu* (Jesus is the eternal blessing).' As they sang, my heart started to pound in my chest.

"Two women from the church came over to me and said, 'Come to the gospel and Jesus will free you from alcohol.'

"I answered, 'Give me one week and I will get saved.'

"This wasn't the first time I had thought about this. My young brother was saved, and he was always telling me to get saved. And this was the time when my friends were seeing me as a nuisance and didn't want me near them. I didn't have any money left and had sold everything that I had. I had begun to realize that my drinking was a serious problem and had even told that young brother that I was going to jump in front of a car and kill myself. I had also started having strange dreams that left me weakened when I woke up.

"The next morning, I went to see the woman at the bar for my morning bottle, as I always did. That morning I drank and even brought some home, I don't remember what I had sold then to buy that bottle. I went to my stack of bricks, drank, and slept.

"When I drank on that particular day, I woke at around 3:45 p.m. and I saw the Lord. I can't say it was a dream, but I saw him. I woke abruptly, and I was sweating heavily. In the vision, the Lord was wearing clothes like a caterer."

"Like a chef?" George asked, thinking he had misheard.

"Exactly! He was up on wooden stairs, and I tried hard to reach him but couldn't. He said to me, 'Child, you have refused to leave alcohol, but I am here mending my shoes.' For sixteen years I have failed to interpret this vision. It could be that I didn't hear well, but that's what he told me.

"I woke up again a few minutes later, sweating heavily, and my heart was telling me, 'Go and get saved, otherwise you will die of alcohol.' I stood up. As I reached the water tank over there, my younger brother who had got saved before came. I told him, 'I am going to get saved. The Lord has asked me to get saved.' He doubted that I was serious, but he said, 'I will go with you.' He went and got his bicycle and drove me until we reached Christian Glory Center.

"At that time, the road to the church was still narrow and bushy, but Pastors Christopher, Charles, and Andrew were there. Pastor Christopher saw me from about thirty meters away and shouted to me 'You man, you really are blessed by God.'"

"Before he even knew you?" George asked.

Kajumba stopped talking and started to cry. George stopped talking too, and both men sat in the sitting room in silence for a few minutes as Kajumba's tears streamed down his face. After some time, Kajumba composed himself and continued.

"Pastor told me, 'You were about to die in just a matter of hours.' And it was the truth because I really was about to throw myself into the moving cars speeding down Entebbe Road. The pastor then asked, 'Why have you come here?' I said, 'Pastor, I have come to get saved.' He told Pastor Charles, 'Go and pray for that man.' Pastor Charles took me to the church, which was small at that time. Inside the church, we also found a niece of mine, another girl who was always asking me to get saved. When she saw me, her face lit up with joy and she said, 'Uncle has come to get saved!' Pastor Patrick began to pray for me and that is when I lost consciousness. When I woke up, my niece was still there, waiting for me.

"This was a Friday. Pastor Andrew was the first person who gave me clothes to put on the following Sunday. He also gave me a Bible. I, the person who never bathed, never shaved, realized at that time how filthy I was. Something big dispossessed me and then I realized how dirty I was. At home, I told my mother how I got saved. But she replied in a mocking voice, 'Got saved? Glory be to the Lord.' She thought it was a joke.

"[When I went to church on Sunday], the service bored me at first. [After the service], I went to Pastor Patrick, and he asked who I was. I told him, 'I am the man Kajumba who you prayed for.' He was amazed. He had thought I wouldn't stick to it, but indeed God had changed me instantly."

. . .

This story is a testimony. While Kajumba rarely shares it publicly, it is a narrative that is intended to convince us, and others who might be converted, that God can heal people and act in their lives. It is also intended to give praise, glory, and

thanksgiving to a God to whom Kajumba himself remains deeply and sincerely devoted. As such, this story would find an easy place in one of the many slim glossy-covered devotional tracts published by both Ugandan and American pastors that one finds for sale on street corners and bookshops in Kampala. But what are we to do with such a story, here at the start of a book that is not a devotional text?

While Kajumba's story is indeed extraordinary, it is not at all unusual to hear such stories in Uganda. This is true both in the sense of the severity of the difficulties he faced because of his drinking and in the way he eventually escaped from those challenges. Problems that addiction researchers would term alcohol use disorders are common in Uganda. A recent study estimates that nearly 10 percent of adults in Uganda have an alcohol use disorder (Kabwama et al. 2016), and the per capita consumption rate among drinkers is among the highest in the world (World Health Organization 2014). However, as Kajumba's story reveals, biomedical models of these problems and of the pathways that might lead towards their resolution are not the only or even the dominant framework for understanding and addressing these issues.

As should already be clear, Kajumba's understanding of his transformation differs in significant ways from the prevailing biomedical model of addiction. Since the 1990s, clinicians, policymakers, and members of the public in many countries have increasingly been taught to think of addiction as a chronic relapsing brain disease (CRBD). Under the CRBD model, addiction is understood to be a problem of individual biology that results from the permanent effects of drugs and alcohol on a person's neural circuitry. This model both diverges from earlier stigmatizing models of addiction that centered on an individual's weakness of will (Valverde 1998) and replaces earlier clinical attempts to cure addiction through the use of various physical and chemical techniques (Campbell 2007). Importantly for the purposes of this book, the CRBD model also casts addiction as a problem that can be managed, but never cured. And so, while the idea that addiction is a disease rooted in biology might free a person from the stigma of earlier moralizing models focused on the will, the focus on chronicity certifies that one is consigned to a life of inescapable repetition, and this too may be a heavy burden to bear (Garcia 2010). In this book, we explore the affordances (Keane 2016) of ways of viewing and experiencing addiction and recovery that diverge from the CRBD model for Ugandans attempting to leave alcohol behind. While the idioms of deliverance, aversion, and possession that you will find in the chapters of this book are at times severe, we argue that they contain within them concepts and practices that point away from models of addiction as a chronic relapsing brain disease and towards the possibility of release.

Kajumba's story also presents an opportunity for anthropologists to broaden their understanding of processes of ethical transformation to better accommodate the effects of spiritual experiences and the diverse range of understandings of

agency and ontology that underpin these experiences. In diverse contexts around the world, people's narratives of ethical transformation often involve the voices and actions of nonhuman others. God's voice is heard in prayer. Ancestral spirits enter the body and demand a response. Life-transforming guidance is received in dreams. Yet, with several key exceptions (Mittermaier 2012; Lambek 2010; Stonington 2020; Qu 2022), anthropologists working to understand processes of ethical transformation in anthropology have sidelined these aspects of people's stories. So, while some anthropologists have given careful thought to how cultural discourses and practices might produce spiritual experiences (Luhrmann 2012; Csordas 2002; Cassaniti and Luhrmann 2014), less is known about the effects of these experiences themselves. This book takes an agnostic approach to the actual sources of such experiences, seeking not to explore why such things happen, but rather what effects these experiences have in people's lives.

In so doing, we draw on four years of collaborative fieldwork with Ugandans working to reconstruct their lives after attempting to leave problematic forms of alcohol use behind. Given the relatively recent introduction of Western ideas of alcoholism and addiction, most of these people have used other therapeutic resources including herbal emetic therapies, engagements with spirit mediumship, and forms of deliverance and spiritual warfare as they are practiced in Pentecostal churches. Each of these therapeutic forms is grounded on a different understanding of agency, the self, and the social, and these can have profound consequences for the forms of life and sociality that may follow an effort to stop drinking.

Practitioners of these various forms of healing not only hold radically different understandings of the causes of problem drinking, but these understandings are underpinned by different understandings of the nature of reality itself. A psychiatrist might look to the interactions between genetic and environmental factors and the long-term effects of substance use on the brain, while a Pentecostal pastor might see the same problem as resulting from the interference of a demon. These two not only disagree about the cause of the problem, but about the existence of demons and their effects in the world. That said, while a Pentecostal pastor and a spirit medium might both engage in a world where spirits and other intangible beings exist and can act as causal agents, they may fiercely disagree with one another about the nature of those beings and how one ought to relate to them. As you will see in the chapters that follow, while people sometimes engage in different medical and spiritual practices simultaneously or in sequence, they navigate this terrain with care and see their choices as having serious stakes for their spiritual and material safety.

In recent years, anthropologists have become increasingly interested in "taking seriously" the realities, the ontologies, of their interlocutors (Candea 2011; Holbraad and Pedersen 2017; Archambault 2016; De La Cadena 2010; Holbraad and Viveiros de Castro 2016). This book is in part an effort to explore what it

might look like to do this with groups of people who radically disagree with one another on these most fundamental questions.

Finally, in attending to the fruits of these vernacular therapeutic forms, this book also argues for giving renewed attention to forms of indigenous medical and spiritual practice in the medical anthropology of Africa. While these therapeutic forms differ from one another in substantial ways, they all point towards possibilities for re-conceptualizing addiction, recovery, and ethics that may prove relevant well beyond Uganda.

DRINKING PROBLEMS

In 2007 and 2008, China and George were working together on her dissertation research on NGOs in the villages where George had grown up. Despite their varying areas of focus, most of the NGOs working in the subcounty claimed to be working with a "sustainable," "holistic" model that incorporated issues as disparate as small-scale enterprise, early childhood play, personal finance, sex education, malaria prevention, food storage, schooling, and nutrition into programs that could ideally be sustained without external funding through ongoing community volunteerism (Scherz 2014). Yet, despite this broad array of concerns, one topic that appeared again and again in the interviews and casual conversations China and George had with their neighbors was conspicuously absent. Alcohol use, abuse, production, and sale were central elements in the stories people told about why this or that child was in or out of school, why a particular old man had been abandoned by his children, or conversely why another family was prospering through the brewing of banana beer. Yet these situations did not find a ready slot on the holistic list of development interventions, a standard slate of "African problems." Food security, deforestation, corruption, education, AIDS, war, water, and malaria figured prominently on this list; alcohol abuse did not. When alcohol use was mentioned in conversations with NGO employees, it was framed as a reason not to engage with a particular person or family: "You can't give anything to that one, he'll just drink the money!" As you might imagine, this left many of the most vulnerable children in the community outside the purview of development interventions. At that time, the absence of interest in alcohol in development circles[2] was paralleled by relative silence in the medical community and in the Ugandan national media. Alcohol was not part of the way scholars, journalists, physicians, and development workers had learned to write and think about Africa (Wainaina 2005).

This is not because the high rates of alcohol consumption were unknown. As China grew increasingly interested in these forms of silence around drinking, she started searching for articles related to alcohol in Uganda during her occasional trips to Kampala's internet cafes. She quickly found several articles that cited a set of WHO statistics listing Uganda as having a per capita consumption rate of

19.47 L of pure alcohol per year, giving the country the highest per capita alcohol consumption rate in the world (World Health Organization 2004). The American magazine *Time* featured a story entitled "The Battle to Stop Drink from Destroying Uganda" (Gatsiounis 2010). *Vice* (2012) produced a documentary entitled "Uganda's Moonshine Epidemic." Yet neither these more spectacular forms of international media attention nor quotidian neighborhood conversations seemed to be filtering into government policy or NGO agenda-setting.

This lack of interest in alcohol was also surprising given the works of scholars including Justin Willis (2002), Simon Heap (1998), and Emmanuel Akyeampong (1997) who have written extensively on the role of alcohol in African political history. Reading their works, one finds alcohol use, production, and trade at the center of a wide range of colonial debates. In colonial Nigeria, customs duties from imported liquor made up more than half of state revenues in certain areas during the first half of the twentieth century and were at the center of fierce debates over the relative importance of temperance and treasury (Heap 1998; Olorunfemi 1984). In the colonies of Central, Southern, and Eastern Africa where the 1890 Brussels Act banned the importation of intoxicating liquors for African consumption, the regulation of domestic beer brewing, sale, and consumption were areas of intense contestation (Willis 2002; Crush and Ambler 1992). In South Africa, there were boycotts against the sterile methadone-clinic-like beer halls where beer was dispensed to Africans (La Hausse 1988). In Uganda, Kenya, Tanzania, and Ghana the consumption of unlicensed beer and gin figured as acts of both dissent and desperation (Willis 2002; Akyeampong 1997).

The first version of the project that became the book you are reading now was focused on trying to understand how it was that alcohol had fallen out of public debate and why it was that it had not returned. Yet, as China began to track this story at a distance by compiling a database of Ugandan newspaper stories related to alcohol with her undergraduates, something surprising started to happen. While it was not as though there was nothing about alcohol in the earlier papers, there was a marked shift in the number of articles referencing alcohol between 2007 and 2017. In 2007, the newspaper *The Monitor* featured 22 articles referencing alcohol; in 2017, there were 113. These articles covered a whole range of issues: traffic accidents, deaths from impurities in tiny plastic tot packs of waragi produced by unlicensed distillers, new packaging and promotions, the multinational drinks industry's growing interest in expanding its market share, and targeted attempts by the Ministry of Health and several emergent civil society organizations to generate media attention through the sponsoring of press conferences and workshops. Something was changing, if not in Ugandan society, at least in the Ugandan English-language print media.

There also seemed to be an increasing interest in substance abuse, mental health, and noncommunicable diseases among practitioners and scholars of global health (Beaglehole and Bonita 2009). A small but expanding number

of studies were documenting linkages between high levels of alcohol consumption and morbidity and mortality from diseases like HIV (Bajunirwe, Bangsberg, and Sethi 2013; Wolff et al. 2006; Kagaayi et al. 2014; Karamagi et al. 2006; Kerridge et al. 2014; Kiwanuka et al. 2013; Ssekandi et al. 2012; Martinez et al. 2008; Mbulaiteye et al. 2000; Musinguzi et al. 2014), tuberculosis (Kirenga et al. 2015; Macintyre 2011), cancer (Cook 1971; Qian et al. 2014), and alcohol-related liver diseases (Schwartz et al. 2014). Researchers were also exploring links between excessive alcohol use and a variety of social problems including child maltreatment (Culbreth et al. 2021), intimate partner violence (Zablotska et al. 2009), and homelessness (Swahn et al. 2018).

Over time, we came to see these popular and scholarly articles as evidence of a larger process of problematization (Foucault 1997; Rabinow 2003), a process of defining and naming, of transforming unproblematized "difficulties" or "quasi-events" (Povinelli 2011) into problems that can be seen and addressed. The process of problematization takes the chronic, cruddy, cumulative, and corrosive aspects of life that "constitute "the 'slow rhythms' of lethal violence" (153) but which "never quite achieve the status of having occurred or taken place" (13). The process of problematization transforms these diffuse difficulties into a crisis that can be publicly addressed.

Statistics are often central to the process of transforming these quasi-events into more catastrophic ones that demand public attention (Povinelli 2011; Hacking 1990; Foucault 2009) and statistics certainly played such a role for researchers, health practitioners, and policymakers in Uganda as they attempted to draw attention to the severity of alcohol-related problems. Much of this process focused on the statistics on alcohol consumption in Uganda that the World Health Organization released as part of their 2004 Global Status Report on Alcohol, which China too had found back in that Kampala internet cafe. While this 2004 figure was likely based on a methodological error,[3] it was spectacular, and spectacles can take on a life of their own. When cited in local and international newspaper articles, documentaries, and television programs, this number had the capacity to transform the corrosive ordinariness of heavy drinking—the hangovers, the arguments, the emptied savings—into a per capita consumption rate that could be identified as an emergency capable of commanding national and international headlines. These statistics also laid the groundwork for the production of other more specific epidemiological data on the health effects of alcohol in Uganda, giving the researchers who contributed to the recent uptick of papers a powerful number to cite as they made their grant applications for these studies.

As you will see throughout this book, this process of problematization remains ongoing. In addition, the task of creating an audience eager to pursue the sorts of services provided in treatment centers and AA fellowships was, and remains, contingent on developing yet more specialized forms of awareness. Specifically, the survival of these programs is dependent on establishing "alcoholics," "addicts," and

"people in recovery" as particular "kinds of people" (Hacking 1986), as people who can be classified as belonging to "definite classes with definite properties." This process also depends on convincing people of the benefits of engaging with the psy-professionals among the middle and upper classes (Vorhölter 2017).

As in other instances of "making up people," this process involves many players, not least of whom are practitioners of the human sciences such as medicine, psychology, and sociology. Through their efforts to count, correlate, and biologize, they engage in processes of discovery which not only describe but also radically transform the lives of those they seek to classify and understand. To be sure, much of the addiction research that is central to this process happened long ago, and far away from Uganda, in clinics, laboratories, prison farms, and communities in the United States (Campbell 2007). Indeed, little research on addiction treatment has been carried out in Uganda or anywhere in sub-Saharan Africa. Nevertheless, as we will discuss in greater depth in chapter 2, this way of "being a person" has been brought to Uganda by people living in Uganda, both Ugandans and expatriates, who were concerned about the problem drinking they saw around them and who had enough exposure to American models of addiction to think that they might be useful.

While tracking the emergence of this new field of practice is part of what concerns us in this book, as this project took shape another thing began to happen in our own thinking. As we lifted our gaze from what was, or was not, happening in the hospitals and NGOs, we soon realized that there was a great deal taking place around the problem of alcohol in other areas of Ugandan society. While drinking is certainly a socially acceptable practice in Uganda (Ssebunnya et al. 2020), distinctions between those who drink well and those who drink in ways considered to be problematic are also topics of whispered gossip and hot debate at places like the small roadside bars where we have been regular visitors since 2015. While there was indeed a growing level of public concern over alcohol use and addiction in Uganda, these conversations were happening without reference to these new terms and seemed to be anything but new.

In Luganda, the language most often spoken in the central region of Uganda and in the capital city Kampala, people whose drinking is seen as problematic may be referred to in these conversations as *omutamivu* (a drunkard), derided as *kanywa mugule* (a person who drinks while others buy for him), or gossiped about as *ekiwanga okusala leerwe* (a person whose head has crossed the railway tracks).[4] Most notably, given the importance of questions of self-control and agency in this book, men who drink in ways that are considered problematic may be derisively referred to and feminized by others with the saying *omwenge gwamuwasa* (alcohol has taken that man as his wife), implying that that person is now being controlled by alcohol in the way that a woman might be controlled by her husband. These categorizations imply an undesirable loss of self-control and self-rule (*okwefuga*), and are most often used when drinking leads to overspending on alcohol for oneself and others. Yet, despite the similarities between this purported loss of self-control and the metaphor of the hijacked brain common in American addiction discourse, these names point

to something other than addiction and do not necessarily carry with them the idea of a chronic disease, rooted in biology, that is at once incurable and manageable.

THERAPEUTIC PATHWAYS

Even more important than our sense that alcohol-related problems were being spoken about in ways that exceeded the bounds of addiction discourse was our growing awareness that there were other ways of responding to these problems that were already operating in the "treatment gap" (Bartlett, Garriott, and Raikhel 2014). While a growing number of people seeking help for problems related to alcohol were enrolling in rehabilitation centers, others were seeking care outside of these institutions.[5] At its most basic level, this book is an attempt to explore the lived experience of people navigating a therapeutic ecology (Langwick 2008), which is both medically and religiously plural. Given the ways that life in Uganda is shaped by neoliberal ideas, we might do equally well to think of the relationships between these different therapeutic alternatives through the related metaphor of the marketplace.

In so doing, we describe the diverse explanatory models (Kleinman, Eisenberg, and Good 1978) through which different practitioners and patients come to understand and define situations in which alcohol has begun to create serious problems. While the specific treatments may differ, at a broad level these same four therapeutic pathways are often engaged as people work to resolve problems in their lives, including problems with other substances like tobacco, marijuana, and opioids and problems with addictive behaviors like gambling. People's engagements with these pathways also go well beyond substance use and may involve a wide array of medical, social, economic, and psychological issues.

Rehabilitation Centers

As we will discuss in chapter 2, several inpatient rehabilitation programs have emerged in Kampala over the past decade, but these programs still only reach a tiny fraction of the Ugandan population that has been estimated to be alcohol dependent. These centers include a government-funded thirty-day residential program offered to people with alcohol and drug addictions free of charge and a number of private clinics of varying levels of formality. These programs largely follow the Minnesota Model, applying principles drawn from Alcoholics Anonymous (AA) in an in-patient setting. Despite the low cost of the public center, most of the patients at inpatient rehabilitation centers in Kampala are male, speak English fluently, have attended university, and come from wage-earning families with relatively high incomes. Some former patients from these centers continue to see each other at Kampala's two AA meetings, and some have gone on to form an NGO dedicated to supporting Ugandans living in recovery. As is true in many contexts influenced by Euro-American models of addiction and recovery, individualistic models of the will, the self, and of personal responsibility are classic

themes for staff members working at these sites. Patients are taught to take responsibility for their future actions, advised to cut ties with old friends, and encouraged to think about addiction as a genetically determined condition.

Herbal Medicine

In Uganda, almost every plant is used to treat at least one disease or ailment. In rural Central Uganda, most homes grow at least one plant for the medicinal properties of its leaves, bark, roots, flowers, or fruits. The most common ones treat fever, coughs, skin infections, and issues related to pregnancy and childbirth. Others might be used to treat fresh wounds, fractures, or sexual problems. Most commonly, green plants are squeezed to produce juice, and this juice is drunk or used for bathing to stop or prevent a disease.

In addressing alcohol-related problems, herbalists typically engage in a form of aversion therapy by providing patients with an emetic that can be added to either alcohol or water to induce an episode of violent and uncontrollable vomiting. Family members and friends sometimes administer this treatment without the patient's knowledge or consent. These emetics are produced from several different plant species, and the herbalists we have worked with each use slightly different formulations. In all cases, they have asked us not to name the specific plant species in our writings due to fears of exploitative bioprospecting (Hayden 2003; Osseo-Asare 2014). Respecting this request, we will not include the Kiganda or Latin names of specific plants in this work. The ingestion of this emetic is thought to induce a permanent aversion to alcohol by causing the patient to find its smell repulsive. Due to the scarcity of some of the plants used to produce this medicine, it is relatively expensive to purchase it; a single course of treatment might cost between 50,000–300,000 UGX or 15–60 USD. Even on the lower end, this amount might represent a significant portion of a month's income and would be considered a major purchase.[6]

Pentecostal Churches

Uganda is approximately 83 percent Christian (UBOS 2014), and religion features prominently in many aspects of everyday public and private life (Scherz 2014; Boyd 2015; Zoanni 2019; Eisenstein 2021). While Catholics and less-observant Anglicans drink openly, Pentecostals generally avoid alcohol, and the problems of excessive alcohol consumption are common topics in their church services and other prayer sessions. The approach to addiction found in these churches focuses on the theology and practice of spiritual warfare. Under the logic of spiritual warfare, all problems arise from the interference of Satan and other demons in people's lives. Helping people to overcome their problems requires that they learn how to uncover, release, and avoid "bondages" that allow Satan to bring problems such as alcoholism, poverty, and illness into their lives and the lives of members of their extended families. While scholars have often focused on the bounded individualism of Christianity, this understanding of spiritual warfare makes clear that this individualism can exist in tension with understandings of the self in which

actions and character are deeply influenced by other people and spiritual beings (Daswani 2015; Bialecki and Daswani 2015; Coleman 2011). This way of thinking about addiction also differs substantially from the model put forward by Alcoholics Anonymous, and the disease model of addiction more generally, with regard to the question of permanence. In the disease model, addiction may be framed as something genetic, or something acquired, or some combination of the two, but whatever the cause it is seen as something permanent. By contrast, practitioners of spiritual warfare see addictions as potentially temporary.

Empewo

Most of the Pentecostals we have come to know through this study have complex, and often adversarial, relationships with practitioners of Uganda's traditions of indigenous healing—particularly when herbal medicines are combined with an engagement with what may be termed "powers" or *empewo* (literally, winds). In Buganda, specialists called *basamize* address a wide range of misfortunes.[7] Like the Pentecostals involved in the practice of spiritual warfare, they approach drinking problems through efforts to mediate the relations drinkers have with an array of beings that we might refer to as intangible persons (Thornton 2017), copresences (Beliso-De Jesus 2015), or special beings (Orsi 2018). Such spirits are thought to drink the alcohol owed to them through the bodies of those they possess. Yet where the Pentecostals seek to exorcise these spirits, the basamize seek to attend to these spiritual relations through ongoing and mutually beneficial forms of care.

. . .

As is the case for other maladies and misfortunes, people often sought out more than one of these methods, either simultaneously or in sequence. The paths that people trace between these various therapeutic alternatives are in part shaped by their religious commitments and their varied understandings of the compatibility between different medical and religious practices. While some of the Christians we met in the Pentecostal churches described the rituals of the basamize as spiritually dangerous acts that courted the demonic and sought to distance themselves from any association with these practices, some of the basamize whom we met in the shrines were also active members of their local churches. While our Muslim friend and driver, Noah, emphatically declined our invitations when we asked if he wanted to join us at the shrine, others centrally involved at the shrine also identified as practicing Muslims. When we noticed that they had not eaten the food served to them at the feast, it was not because they felt the food was spiritually dangerous, but because it was still light out and they were fasting for Ramadan. In seeking to understand how people navigate the diverse array of medical and religious practices in Kampala, perhaps the most important thing to remember is that there is no one way that people approach this question. One Catholic might feel relatively comfortable keeping a rosary next to a pipe created to send smoke up to the *balubaale*, while another Catholic might see such a pipe as a Satanic object

that needs to be avoided at all costs. That said, what is perhaps common for many people across all of these stances is a sense that one needs to consider such questions with care, given the possible spiritual, physical, psychological, economic, and social consequences of error.

Further, as the people who shared their time with us navigated this vast and varied medical and religious terrain, they did not go alone, and their choices were shaped by those that walked with them. Their friends, family members, neighbors, and sometimes even the bar owners who sold to them helped to define their therapeutic trajectories. The efforts that family members and friends made to help those they were concerned about also exceeded these therapeutic spaces. Neighbors gave advice, counseled, and pleaded. Parents prayed, told their children to avoid particular groups of friends, and offered them opportunities to establish a more fruitful life by giving them land to work or a small business to run. That said, in the interest of highlighting the specific effects and affordances of each therapeutic pathway, we have pushed the long and winding quests through which people move between these spaces to the background. This process of sequential or simultaneous engagement with multiple therapeutic forms is something that has been thoughtfully engaged by numerous medical anthropologists (Whyte 1997; Janzen 1982; Langwick 2008), and further work in this area with regard to forms of addiction treatment discussed in this book or in other contexts would no doubt be welcome. Nevertheless, we have chosen to focus less on this process of movement than on the internal workings of each therapeutic model and the differences between them.

Finally, while we are sensitive to the problems of "fixing" a person in place in an ethnographic text (Garcia 2010) and quite compelled by writings which focus on doubt and uncertainty (Bubandt 2014; Meinert 2020), on the "moments when facts falter" (Stevenson 2014, 2), we are also aware of the certainty with which neuroscientific models of addiction operate. In the interest of mustering the degree of rhetorical force necessary to counter this, we have purposely chosen to foreground the certainty with which people engaged alternate treatment modalities. This choice also aligns with the sentiments of our interlocutors, most of whom felt quite certain about the truths at which they ultimately arrived—however much they might disagree with one another.

BEYOND THE CLINIC

Our attention to these varied therapeutic pathways takes us far outside of the hospitals and clinics that have become increasingly central in contemporary work on the medical anthropology of sub-Saharan Africa. As China has argued elsewhere (Scherz 2018b), much recent work in medical anthropology has focused on the anthropology of biomedicine, and this has been especially true of the anthropology of sub-Saharan Africa.[8]

Vernacular therapeutic practices were once a topic of great interest to anthropologists and historians[9] writing on medicine and healing in Africa. These works were central to important debates concerning questions of rationality (Evans-Pritchard 1937), foundational to the development of major schools of anthropological theory such as symbolic anthropology (Turner 1968), and crucial to anthropological understandings of how sociocultural orders are reproduced and transformed (Comaroff 1981). Into the 1990s, anthropologists were designing ethnographic studies that offered sophisticated analyses on the battles over truth and power that shape the ontological politics of healing in Africa (Langwick 2010). Yet, while many of the works researched in the 1990s were still making their way through the publication process well into the new millennium, research projects that were conceived and gestated after the turn of the millennium were far less likely to consider vernacular practices in ways and in spaces that are not already defined by the biomedical. With a few exceptions (Thornton 2017; Victor and Porter 2017; Igreja, Dias-Lambranca, and Richters 2008), many of which consider Christian rather than indigenous healing practices (Hannig 2017; Boyd 2015), we now rarely find non-biomedical practices described as part of lived therapeutic ecologies. While earlier works still have much to offer, one can neither assume that their descriptions are consistent with present practice, nor that present theoretical concerns would not cause an anthropologist to notice quite a different set of details.

The decreasing focus on vernacular healing in medical anthropology is by no means limited to sub-Saharan Africa. Much of the work done by medical anthropologists around the world is now focused on the lives of health workers, patients, and things in hospitals, clinics, and health-related NGOs (Lock and Nguyen 2010). This trend may be an unintended consequence of the otherwise laudable shift towards critical medical anthropology and its much-needed focus on the systems of power and structures of violence that operate both within and outside of medical systems to create health disparities (Das and Han 2015). It also reflects a growing division between medical anthropology and the anthropology of religion (Whitmarsh and Roberts 2016). Works such as those by Elizabeth Roberts (2012), Sherine Hamdy (2012), and Alice Street (2014) show us how non-biomedical ideas and practices shape the life of the clinic, but still, the clinic remains the site and limits the discussion of these elements to the ways that they appear in spaces already defined by biomedicine.

While biomedicine is clearly present and should not be ignored, attending to the ways that biomedicine articulates with vernacular healing practices has displaced other possible questions we might ask about those practices themselves. To be clear, we have no interest in questing after a pure or unadulterated version of "traditional" medicine, but there may be a great deal to be learned by exploring the more expansive sources of the fragments that appear in clinical spaces.

When anthropologists fail to do this, they leave open major gaps in our descriptions of the ways many contemporary Africans, both urban and rural, live in relation to the vernacular therapeutic offerings in their cities, towns, and villages. Anthropologists often tell our readers that the medical offerings are plural and that they are shifting, but in the most recent writings on medical care and healing in sub-Saharan Africa, the descriptions of biomedical and developmental spaces are typically far more detailed than the descriptions of more vernacular sites. We know from anthropologists of global health like Adia Benton (2015) that the coverage by biomedicine is radically uneven, focusing on some illnesses, while ignoring others. With that discrepancy in mind, we need scholarship that describes not only what happens to the few caught up in the biotechnical embrace (Good 2001), but also what happens to the people whose quests for therapy lie primarily outside of it. Given the contingency of global health funding in our current political climate, it may well be the case that the number of those who find themselves outside of the clinic is growing rather than shrinking.[10] Finally, if one of the key things we know about "traditional" healing practices in sub-Saharan Africa is that they are constantly changing (Obbo 1996), we cannot let older ethnographic and historical accounts serve as a substitute for contemporary ethnographic work when we refer to what may be happening outside of the clinic in the present.

Further, as Stacey Langwick has eloquently argued, questions concerning the status of traditional medicine are deeply political ones. They are questions related to a "highly politicized and intimate battle over who and what has the right to exist" (2010, 232). While medical anthropologists working in Africa have followed Langwick in noting the political stakes of colonial and postcolonial efforts to sever the phytopharmaceutical aspects of African medical systems from their more political and religious elements (Droney 2017; Adu-gyamfi and Anderson 2019), anthropologists have been markedly less careful about their own continued participation in the dividing practices (Latour 1991). Where medical anthropologists and medical historians were once concerned with a broad range of healing practices that blurred the lines between the physical, the spiritual, and the political, more recent works have tended to focus on various aspects of phytopharmaceutical research (Droney 2014; Osseo-Asare 2014). These works are important and may help us to better understand new realities on the ground, but they also leave out the vast majority of healers and patients who have no connection to such institutions. These healers' lives may also reflect new realities that merit our attention, but they are harder to see at a distance.

There are also other dividing practices at stake in contemporary ethnographic writing on hospitals and laboratories linked to questions of time, of tradition, and of modernity. Some of these works seem to say, "Look! Africans are modern too." These works, are, in this way, not so unlike the Manchester School ethnographies produced by the members of the Rhodes Livingston Institute in their celebrations of Africans embracing modern Western practices (Wilson 1942). In so doing, they

assert, and helpfully and accurately so, the similarity, the coeval belonging (Fabian 1983), of certain sites in Africa and in the worlds of their readers, a group presumed to be students and faculty members at universities in the Global North. While there are certainly apartment complexes, shopping malls, NGO offices, and laboratories in Kampala that easily fit this pattern, there are also places like the shrines of the basamize you will meet in chapter 5. These shrines are not part of the past. They are also not only found in remote villages; the one that concerns us in this book is in the center of Kampala. We could tell you truthfully that many of those who spend their days there spend much of their time talking about their work as land brokers, pouring over sports betting sheets, and attempting to realize their aspirations for music video production contracts. We could tell you about one who proudly told us about his daughter's recent enrollment at Makerere University, where she was seeking her BA in chemistry. Yet, it is not these things that make these healers, and their patients, coeval members of your own time. They are part of your own time because they are presently living. That they also think deeply and live their lives in relation to spirits and rituals that medical anthropologists working in sub-Saharan Africa rarely write about anymore, does not make them less so, and their practices need not be *about* modernity to be *part of* modernity (Sanders 2003).

Part of the studied neglect of vernacular healing practices, such as those undertaken by the basamize, may be a fear of portraying Africans as essentially irrational or unmodern. But, like a second-wave feminism that asserted that women could, in fact, be just like men—thus implicitly elevating those characteristics that were associated with men—in our avoidance of this area of healing and harming, we also, subtly, and perhaps inadvertently, shore up the value and legitimacy of "modern" "Western" practices. Biomedicine certainly plays a role in contemporary African life, but if the next generation of medical anthropologists working in Africa becomes too firmly entrenched in the clinic, the discipline will miss out on the tremendous richness that African traditions, hybridity, and cosmopolitanism have historically provided for our thinking about the diversity of human practice and experience. Such work requires sustained engagement with local languages, with the history of anthropology, and with field sites that are less easily visible on maps or in the media. Overcoming these obstacles is not impossible, but doing so will require that anthropologists think carefully about which projects are worthwhile and why it is that they think so.

Finally, these erasures are problematic not only for the political and empirical reasons laid out above, but also for the pragmatic reasons long championed by anthropologists. Quite simply, vernacular healing practices in Africa may have much to teach us about how people anywhere might best respond to the illnesses that shape and cut short our lives. We must not only keep a critical eye on the social determinants of health, the inadequacies of biomedicine, and the global movements of pills and practitioners, we must also look to these vernacular

systems as places to learn *from*—and this must be equally true of Africa as it is for Tibet, Nepal, China, or India. We often say that biomedicine discounts these practices, but in ceasing to devote our scholarly attentions to them, we implicitly do the same.

We have only begun to explore what these practices might have to teach us in terms of healing our bodies and minds. This may be especially important for those illnesses that biomedicine still is not particularly good at addressing, things like pain, addiction, and mental illness. While the global health apparatus is busy trying to export biomedical remedies for these conditions abroad (Watters 2010), even as the efficacy of these remedies has been questioned at home, medical anthropologists might be more involved in exploring how these conditions are approached in places where people have developed different ways of understanding and approaching them.[11] What, for example, might we learn from Duana Fullwiley's (2010) work on the management of pain in Senegal? What is it about the management of schizophrenia in Zanzibar (McGruder 2004) that leads to increased wellbeing among sufferers and their families? How might practices related to the care of plants and people create new spaces of habitability in an increasingly toxic world (Langwick 2018)? As these citations indicate, there is already some work that hints at these potentials, but there is room for so much more.

Likewise, while a few works in the anthropology of addiction have looked at alternate ways of conceptualizing and addressing substance use disorders, the general decline in the scholarly energy dedicated to non-biomedical healing traditions in medical anthropology has also shaped much of the anthropological work in this field. In the earliest phase of work on substance use in anthropology, anthropologists were so focused on describing situations in which drinking was not constituted as a problem (Douglas 1987; M. Marshall 1979) and on the surprisingly wide range of ways that drinking shaped behavior (MacAndrew and Edgerton 1969; Heath 1995), that some worried that the field was ignoring what might, in fact, be serious alcohol-related problems in the communities under study (Room 1984). Since that time, anthropologists studying addiction have shifted their approach to focus on the limits of the universalizing medicalized vision of addiction as an individualized pathology. Most have done this by following Merrill Singer (1986; see also Singer et al. 1992) in analyzing the social determinants of substance abuse.[12] Other anthropologists and historians have focused on tracing the genealogy of contemporary biomedical addiction discourses (Valverde 1998; Campbell 2007; Netherland and Hansen 2016a, 2016b; Raikhel and Garriott 2013) and exploring how this discourse is altered as it moves across cultural contexts (Raikhel and Garriott 2013; Borovoy 2005; Brandes 2002; Prussing 2011; Harris 2016). In writing this book, we join a small but growing number of scholars who have sought to explore what lies in the "treatment gap" (Bartlett, Garriott, and Raikhel 2014). These scholars have drawn attention to the contingency of medicalized approaches to addiction by exploring other ways of conceptualizing and

responding to problems related to substance use (Gamburd 2008; Spicer 2001; Raikhel 2016; Garcia 2010; Hansen 2018; O'Neill 2019; Bartlett 2020). In focusing our efforts on understanding other ways of living life after alcohol, we want to think about the ways that these alternatives might offer generative visions for an otherwise view (Zigon 2018; Povinelli 2011; Robbins 2013) to the dominant chronic relapsing brain disease model.

ETHICS, AGENCY, ONTOLOGY, AND EXPERIENCE

Beyond these concerns related to medical anthropology and the anthropology of addiction, this is also a book that aims at intervening in conversations about the anthropology of ethics, agency, ontology, and experience. Like so many of the stories we heard over the course of our time talking with people about their efforts to leave drinking behind, Kajumba's story hinges on a dream, a vision. His vivid half-waking encounter with God—dressed as a caterer and mending his shoes, calling him to get saved—crystalized a series of happenings that came before and pushed him towards the series of social and supernatural interventions that followed. Before the vision, there was Kajumba's father throwing him out of the house, his near-suicidal despair over the condition of his life, his brother asking him to get saved, his heart beating while hearing the song at the crusade, and his promise to the two women who approached him. These were all key elements in his transformation. After the vision, there was the pastor who recognized him as he approached the church, his brother's willingness to drive him on his bicycle, the appearance of his niece, Pastor Patrick's prayer of deliverance, his loss of consciousness, and Pastor Andrew's gift of the shirt. While the more social elements of the before and the after are fairly comfortable ground for social scientific analysis, the more miraculous elements, such as the vision itself, are things we are less likely to encounter in writings on ethico-moral transformations.

Had Kajumba focused his story on a series of daily practices through which he worked to transform himself into a new kind of person, we would have a clear sense of where to look in the anthropological literature for analytical tools. Over the past fifteen years, anthropologists studying processes of ethical transformation have focused on moments of evaluative reflection and intentional projects of self-cultivation. These scholars have all used Michel Foucault's later works (Foucault 1990; 2005) as a model for illuminating the ways that people take up particular exercises of self-cultivation in an effort to align their desires, habits, and actions with various moralities and understandings of the good (Mahmood 2004; Faubion 2011; Robbins 2004; Rabinow 2003; Zigon 2011; Scherz 2013). Yet, while the focus on intentional action and reflexive thought that characterizes this approach has provided a helpful corrective to overly determinist frameworks for the study of morality and social life more generally (Laidlaw 2013), it also comes with certain limitations. Specifically, in this effort to better incorporate freedom, deliberation,

and projects of intentional self-making, scholars have tended to background other aspects of ethical life and personhood that are less easily controlled (Scherz 2018a).

Among these less controllable aspects are various forms of spiritual experience and the divinities or other spiritual beings who often appear as agents in people's narratives of ethical transformation. The possibility that such beings are involved in collectivities capable of shaping the self has received only occasional attention (Mittermaier 2012; Lambek 2010; Stonington 2020; Laidlaw 2013; Scherz and Mpanga 2019; Scherz 2018a; Qu 2022). This lack of focus is surprising given both people's explicit articulations of divine action as an explanation for personal moral transformations (Daswani 2015) as well as the current disciplinary interest in questions of ontology and phenomenology.

Attending to accounts of the role of spiritual experience in processes of ethical transformation, such as Kajumba's, is a difficult task for several reasons. As noted earlier, there are problems presented by anthropologists' use of the anthropology of ethics to highlight the character and place of freedom in settings poorly served by models that privilege either slavish obedience to culture or unmediated acts of resistance (Laidlaw 2002; Mahmood 2004). Despite other points of divergence among scholars working in this area, there is a sense of agreement that to study ethics is to study the intentional, the conscious, and the reflective. Scholars working on the anthropology of ethics have often focused on the importance of the process of both conscious reflection and intentional action, whether considering moments of moral breakdown among former heroin users in post-Soviet Russia (Zigon 2007, 2008, 2011), the moral experiments of African American parents of children with serious medical problems in Los Angeles (Mattingly 2014), Cairene women participating in Islamic piety movements (Mahmood 2004), the sudden moments of self-awareness and critique that punctuate the lives of frontline community psychiatry workers (Brodwin 2013), or the moral torment of Christians in Papua New Guinea (Robbins 2004). This scholarly work has no doubt provided a helpful corrective to overly determinist frameworks. Yet in this otherwise laudable focus on freedom, we might be drawn dangerously close to a view of the subject as a self-determined individual who experiences, perceives, and lives in relation to a world of others without being directly entered or affected by them.

Attending to accounts in which God, balubaale, or other spiritual beings play significant roles in the constitution of ethical subjects also raises a series of difficult questions about agency and ontology. In short, we have had to decide whether to write of those beings as agents capable of influencing the world directly, or whether we will write only about the effects of the beliefs and practices that people have constructed in relation to them. While many of our interlocutors were deeply committed to explanations that saw spiritual beings as responsible for a given person's struggle with alcohol, as scholars we are still left to decide whether we will write about the effects of the way that that circle of responsibility is drawn (Laidlaw 2013) or about the effects of those beings themselves.

Over the course of the past seven years of research and writing (Scherz 2017, Scherz and Mpanga 2017, Scherz, Mpanga, and Namirembe 2022), we have found ourselves pulled between these two modes of engagement. On the one hand we felt drawn to consider perspectives that would allow us to move beyond an understanding of spiritual experience focused on the rhetorical influence of ritual speech (Csordas 1997) and the human practices that kindle such experiences into existence (Cassaniti and Luhrmann 2014; Luhrmann 2012). We took to heart Dipesh Chakrabarty's (1997) critiques of the disenchanted world of the social sciences and hoped that writings of those identified with the ontological turn (Candea 2011; Holbraad and Pedersen 2017; Archambault 2016; De La Cadena 2010; Holbraad and Viveriros de Castro 2016; Kohn 2015) or indigenous anthropology (Watts 2013; Todd 2016; Bawaka Country et al. 2016; Tallbear 2017) might provide us with a path that would allow us to more fully consider the world as our interlocutors did. Yet, as we will discuss in the conclusion, it may not only be disenchanted social scientists (Chakrabarty 1997) who would be nervous about a book that contained assertions about the agency of spiritual beings. We will return to this question throughout the coming chapters in various ways, but for now, we simply invite you to see what becomes possible and impossible, visible, and invisible, as you shift between thinking about the effects of belief, ritual, and human sociality and the effects of spiritual beings themselves.

HOW WE WROTE THIS BOOK

Life in Uganda has inclined all three of us to convert material wealth into carefully composed networks of relationships whenever we can. As we will discuss in greater depth in the chapters that follow, it is next to impossible to do anything in Uganda without relying on a dense network of relational ties. While the role of relationships in addiction recovery is central to the content of this book, at a more methodological level this book is also an outcome of such a materially mediated relational composition. In taking this approach, we are bringing insights drawn from Uganda and elsewhere in Africa about the ethics of interdependence (Kopytoff and Miers 1977; Guyer 1995; Scherz 2014; Hanson 2003; Comaroff and Comaroff 2001; Ferguson 2013; Cole and Thomas 2009; Zoanni 2018) into the rapidly expanding conversation in the need for more collaborative forms of anthropological practice (Deger 2006; Bejarano et al. 2019; Lassiter 2005), and, in the process, helping to transform a long history of important, but largely invisible, contributions made by assistants and translators in Africanist anthropology (Schumaker 2001).

As mentioned above, George and China's collaboration began in 2007, when China was just starting her dissertation research on orphan support programs in Uganda. At that time, she hired George to work for her as a translator and research assistant, and together they explored the workings of an orphan support program

operating in his home village. Through that project, they developed a collaborative relationship that became the basis for this book. By the time they started working together again on this project in 2015, George had completed his BA at Kampala International University and had also worked as an assistant for several other historians and anthropologists including Jon Earle, Emma Wildwood, Erin Moore, Edgar Taylor, Jacob Dougherty, and Tyler Zoanni. When China asked George to join her in working on this new project about alcohol, she suggested that instead of working as an assistant on the project, he might work as a full collaborator and that they would try to coauthor most of the writings that came out of the project—including the book you are reading.

An initial startup grant from the University of Virginia allowed China to hire George to work on the project on a full-time basis. At the outset, George and China worked alongside one another, both taking notes on the same events and then comparing them afterwards. After the first nine weeks of working in this way, China returned to the United States, and George carried on with the fieldwork in between China's visits to Uganda. During these periods apart, China reviewed and coded transcripts using the web-based mixed methods software Dedoose. The two then met over Skype for two to four hours a week to discuss the notes, transcripts, and their plans, progress, and emerging ideas about the shape of the project.

In February 2018, China received a grant from the National Science Foundation (Award #1758472). This grant not only allowed George and China to continue their work, but also allowed them to hire and train an additional collaborator, Sarah Namirembe. Sarah and George grew up in the same village and had known one another since Sarah was a young girl. George was a friend of Sarah's family and often visited her when she was away at school. It was thus to their mutual delight when we ran into her by chance when she was serving as a volunteer educator in the Alcohol and Drug Unit at the National Psychiatric Hospital. Once she joined the project, Sarah went through a similar training process both with China and with George, learning how to take field notes and conduct interviews. George (July 2015–July 2019) and Sarah (January 2018–July 2019) conducted fieldwork on a full-time basis. China joined the team in Uganda for a total of twenty-four weeks spread over the course of the four years.

Our team has also included our friend Noah Wabwiire, who worked as our driver, our tech support specialist, and later our transcriptionist. We also worked with a number of University of Virginia and Reed College undergraduates including Aubrey Bauer, Emily Weisenberger, Claire Mooney, Likita Griffith, Priscilla Opoku-Yeboa, and Beza Bogale. Most of these students worked with China to build and maintain a coded database of more than eight hundred news articles discussing alcohol drawn from the Ugandan English language print media. Our team in Uganda was also joined by two additional undergraduates, Anne Nelson Stoner and Amber Colby. China and George supervised these students as they conducted six weeks of fieldwork at a Pentecostal church and an inpatient rehabilitation

center during the summer of 2017. Anne Nelson also returned for an additional nine weeks of followup fieldwork in 2018.

During the four years of our fieldwork we spent time and spoke with nearly three hundred people in bars, rehabilitation centers, Alcoholics Anonymous fellowships, churches, herbalist clinics, and shrines. The vast majority of this work took place in Uganda's capital city, Kampala. Kampala has a population of approximately 1.5 million people, with an additional one million commuting into the city for work each day. Given the number and variety of available options, including the country's two major inpatient rehabilitation programs, it provided us with an excellent location for exploring the range of treatment modalities currently available in Uganda.

Given our interest in the ways that processes of personal transformation play out over time, most of our efforts were focused on following twenty-one people who had or were trying to stop drinking. While many of these people had had experience with multiple treatment pathways, they were each primarily involved in one form of treatment at the time of the study. In following this cohort we drew on observations, semi-structured interviews, and the coconstruction of illness narratives. Most importantly, we simply spent time with them, finding them at home, at work, and out with their friends. We were also frequent participants in addiction awareness and fundraising events, church services, educational sessions in rehabilitation centers, rituals held by basamize, and trips to gather herbal medicines in markets and forests.

Our methods, built as they were around following people home as opposed to interacting with people only as they were passing through therapeutic sites for treatment, were explicitly designed to move away from thinking about medical anthropological field sites as defined by institutions. While having a regular "place to go" provides an expedient boundary—something that may be especially welcome in the context of urban fieldwork—we used institutions as starting places but primarily sought to explore the lives of people as they moved beyond the moment of therapeutic encounter. We did this by letting people, rather than sites, define the boundaries of the study.

This process of working together across a wide range of sites has transformed the project into something that none of us could have created independently of the others. At a very basic level, the collaborative nature of the project has allowed us to collect data at a much wider range of sites and over a much longer and more uninterrupted period of time than would have otherwise been possible. At a deeper level, and perhaps more importantly, working collaboratively has allowed us to think about the things we have learned during our fieldwork from different perspectives. Our positions, and our bodies, are read differently by those involved in our research, and this changes what people tell us and how we think about it. When we exchange field notes written about the observations we have made while standing side by side, we often find that we have noticed different things and come

to different conclusions about them. China is a white, female academic from the United States. George is a man from Uganda. The fact that he is a father of twins with involvements in Buganda government affairs, clan leadership, and opposition party politics also changes things for certain people. Sarah is a young Ugandan woman with a BA in community psychology. She is also much more of an insider than either George or China in both the rehabilitation centers discussed in chapter 2 and the churches discussed in chapter 4. All of this changes how she relates to people in these spaces, and in others as well. Because of the racial hierarchies that continue to structure life in the postcolonial nations of Africa (Pierre 2012), China's position as a white academic meant that we were regularly granted meetings with senior hospital administrators, researchers, and Ministry of Health officials (see Covington-Ward 2016; Nannyonga-Tamusuza 2005). But the people involved in the study told George and Sarah things about their lives that they might well have hesitated to share with China. China's knowledge of anthropological theory led her to ask questions that will have relevance to current academic debates, but it was George and Sarah's depth of lived cultural, linguistic, and historical knowledge that often helped us to make sense of the answers.

This method also allowed us to have a series of conversations about how we wanted to write about the things we have learned. As we will address in greater depth in the conclusion, we have, for example, had many long discussions about how to engage with the claims made by healers and pastors concerning the nature and reality of the spirits who enter the bodies of those who frequent shrines. This question inflected our conversations about what implicit and explicit theoretical positions we wanted to take in our writing, and it also inflected our conversations about how to act within spaces like churches and shrines. Talking honestly about our interpretations of the different things we have seen and experienced helped us to better understand the array of approaches people might take to engaging with spirits– and also to better understand the stakes of different kinds of claims concerning the reality of spirits for differently situated people.

This process of cowriting has also afforded us an opportunity to foreground Ugandan perspectives. While there is no one "Ugandan" way of thinking, we have made it part of our collaborative practice to foreground our research participants' own frames of analysis as often as possible. This has involved taking the relevant sections of this book back to the people about whom we have written. Reading the sections aloud, often in Luganda translation, and seeking their feedback has been an invaluable process. In this review process, the people who you will read about in the chapters that follow have added crucial details to their stories that they had left out in earlier versions. They corrected our interpretations and challenged us to write with words and intention that correspond to their own understandings of the world. Working together as a team has made it easier for us to grasp these multiple Ugandan ways of seeing the world. It has also kept us accountable to this goal, if only by making us aware of moments when we chose to do something else.

Writing together also changed how we write in other ways. By coproducing texts from the first writing of field notes to the final draft of this book, writing together allowed us to consider and address questions of accessibility and voice that will ultimately change our readership. Writing together put questions about who and what anthropological writing is for at the center of our work. These questions led us to produce a broader range of writings and other research products. One of these, a twelve-part radio series coproduced in Luganda with CBS-FM Radio Buganda, has been primarily oriented to Ugandans who have not had the opportunity to attend university. We also hope that this book will be relevant to readers both inside and outside of Uganda and that our collaborative writing process has made us mutually accountable to this goal and given us a stronger sense of what might be relevant to these different audiences.

WHAT LIES AHEAD

The heart of this book is comprised of four ethnographic chapters that explore the four types of therapeutic sites in turn. In each of these chapters, the narratives of the people we have worked with are central and offer an opportunity to see how these different modes of conceptualizing and experiencing the self, and their relationships with an array of human and nonhuman others, have shaped their efforts to move towards a life after alcohol.

Before reaching those chapters, chapter 1, "*Batuzaala mu Baara*," discusses the history and social life of alcohol in Uganda. In it we explore the history of alcohol use and regulation in Uganda and the forms of social life that bars make possible.

Chapter 2, "Once an Addict . . . ," takes us into two of Uganda's formal inpatient rehabilitation centers–one public and one private. Within these spaces a new set of identities and ways of being in the world are taking shape. Through daily routines, private counseling sessions, and didactic trainings, some of which were led by Sarah herself before she joined our research team, the clients of these centers are being taught to understand themselves and those around them in radically new ways. Through the story of a young man named Maurice, we explore how trust, class, and new forms of biosocial belonging and isolation intersect with the disease model of addiction as it has been introduced to Uganda.

Chapter 3, "Put Something in His Drink," begins to move us beyond the clinic to the shop of an urban herbalist who treats alcohol-related problems with a form of emetic aversion therapy. Through an analysis of the life history of one of her clients, Mayanja, we explore the affordances of a form of treatment which transforms a person's embodied perception of the world, but which does not prescribe a transformation of one's social ties. Given this, people like Mayanja who stopped drinking through herbal medicine found it relatively easy to maintain their social ties with former drinking companions and generally continued to go to bars to socialize and drink highly caffeinated nonalcoholic beverages like Mountain

Dew and Rock Boom. We explore the effects of their relatively uninterrupted identities and networks of social support in and contrast it with the "total break" prescribed by Pentecostals and addiction counselors alike.

In chapter 4, "Not You," we turn to consider models of spiritual warfare and deliverance as they orient understandings of addiction in a Pentecostal fellowship in Kampala. Within these churches, people are taught to understand addictions as the result of the actions of demonic spiritual forces in their lives. As is also true of the practitioners of *kusamira* you will meet in chapter 5, members of these churches see some cases of problem drinking as caused by spiritual forces. For these Christians, moving beyond problems with alcohol requires them to exorcise the spirit which is causing the problem through deliverance. We argue that despite the apparent severity of the spiritual warfare discourse, this way of understanding addiction leads the members of these churches to see people as fundamentally separable from the spirits that might cause them to drink, and that this understanding creates important opportunities for people to begin again.

In chapter 5, "Call and Response," we focus on a community of basamize who participate in the form of mediumship and worship known as kusamira. While they also see some drinking problems as resulting from the influences of spiritual forces, for them the task is not deliverance, but rather finding ways to better accommodate the spirits by recognizing them and moving into a more productive relationship of reciprocity and mutual care. At both church and shrine, alcohol-related problems can be explained as resulting from the actions of an external force. Where they differ, and here they differ strongly, is about the moral valence of these external spirits and what ought to be done about them.

In the conclusion, finally, we attend to the theoretical challenges and insights that arose in this attempt to explore multiple sites where people have conflicting claims about therapeutic efficacy and about the things, beings, and substances that exist in the world: their natures, their effects, and the relationships between them. We explore how people navigate an array of competing and often conflicting claims to efficacy and how anthropologists might consider the possibilities and limits of the discipline with regard to these questions.

Throughout, our explorations of these varied therapeutic pathways speak to the importance of returning engagements with vernacular therapeutic forms to the center of medical anthropology and to carefully considering the role that spiritual experiences play in processes of ethical transformation. With regard to the latter point, this book considers how the transformative potential of spiritual experiences is shaped by a community's belief in the possibility of transformation, by its willingness to accept that things truly could be different. The collective faith that someone might truly be transformed opens up radically new possibilities for the incorporation of people into new communities of care and relationship. These new relationships are imperative given the importance of relationships in Uganda

and the central role that bars play in their constitution and maintenance. Before moving forward with our discussion of how these different conceptualizations of the self and the social shape the various pathways out of problem drinking, we first turn to consider the forms of sociality that take shape around bottles of beer, jerry cans of *umkomboti*, plastic tot packs of waragi, and pots of *malwa* in the small bars lining so many of Kampala's roads.