

**REPRESENTATIONS, RITUAL, & SOCIAL RENEWAL:
ESSAYS IN AFRICANIST MEDICAL ANTHROPOLOGY**

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¹ Powerpoint "Presentations" accompanied these print chapters and are accessible in pdf format. Photos or diagrams are usually referenced in the text by bold-lettered phrase or name.

I. Introduction

Chapter 1

REPRESENTATIONS, RITUAL, AND SOCIAL RENEWAL: ESSAYS IN AFRICANIST MEDICAL ANTHROPOLOGY

The core of this collection of essays was assembled in 2004 spring sabbatical lectures at Harvard University² and at the Medical University of Vienna.³ Since then I have added other lectures, essays, and a proposal from other projects.⁴ The thematic focus of these writings is on how the signs of sickness and healing shape the production of health, that is the set of cultural understandings, expressions, behaviors, and socioeconomic relations that maintain health and ill health, or restore it where it is broken. This connection between representations and lived experience in health and healing is of interest both from a theoretical perspective as found in a large body of literature in anthropology, history, performance studies, and public health, as well in the inductive portrayal and analysis of specific practices in African societies, particularly in Western Equatorial Africa where I am best acquainted. The Kongo ritual of *dumuna* serves as a foil to explore one such connection between a particular ritual embedded in social practices and assumptions, and the production and reproduction of health. Obviously this is but one of the many representations of how sickness is identified and health restored. A further theme that runs through these essays is that the circumstances of health in Western Equatorial and Central Africa, and the scholarship about it, are distinctive in a global perspective. Otherwise put, to what extent is the particular burden of disease and the way it is approached in these Africa societies unique among human societies and thus to scholarship in medical anthropology? Answering this question yields an Africanist medical anthropology.

Dumuna

A quick review of known uses of this ritual demonstrates how extensive are its networks of meaning and contexts of use, requiring well-honed analytical strategies to understand and to interpret it. In a first use, *dumuna* is done by some healers at the close of a successful treatment, shown in accompanying illustrations of **Kongo doctor/nganga Nzoamambu**. Three times he led the woman between his spread legs. Following that, three times he led her in a kind of jumping handshake. The kink in her lower back clearly loosened, she went of happily to her day in the field. *Dumuna* confirmed this successful treatment.

In another rendering of *dumuna*, thrice jumping action was performed by a representative of the distressed individual's father's clan. The "father" held both hands under the armpits of the distressed individual. Three times he lifted her up in a jumping action, and then pronounced the blessing verbally. This was intended to neutralize any lingering antagonism or ill will, and replace it with the support of

² At Harvard University I was invited to participate in the Working Group on Health, Healing, and Ritual Practice of the "Harvard Africa Initiative," put in motion by Harvard College to articulate curriculum, research, and resources in African Studies. Two lectures were presented to the International Center for Population and Development, where I was a visiting scholar.

³ At the Medizinische Universitaet Wien, formerly a section of the University of Vienna, I was a visiting fellow in the Department of Ethnomedicine and Public Health within the Institute for the History of Medicine. I am grateful to Professor Dr. Armin Prinz for his generous invitation and to Lecturer Ruth Kutalek for her hospitality.

⁴ See first note of each chapter for background on when it was prepared, presented, and subsequently used.

the paternal kindred. *Dumuna* was also embodied in the rites of a North Kongo medicine, called *Dumuna*, as seen in a photo of the **nganga leaping in the air** after contacting the *nkisi*.

A further remarkable documentation of the *dumuna* in Kongo rites shows as the climactic enactment of a healing-inauguration of the *mpu* chiefship. This case will be described and discussed in more detail in chapter 8—"Dumuna: The Power of the Margins & Subaltern Authority in North Kongo (or, Healing Social Contradictions)". In a structural relationship that is the inverse of the paternal blessing *dumuna* of the child, here the *dumuna* is enacted by the patrifilial children—the gathered children of the men of a matrilineage, the political constituency so to speak—upon their father who is being healed and lifted to a sacred position over them. The healing of the father as a prelude to his inauguration is at once also a healing of the community through a re-establishment of authority.

The Church of the Holy Spirit in Africa, one of many independent Christian churches in the Lower Congo, has incorporated the *dumuna* rite as a climactic finale to its worship services. In addition to "the blessing," "the healing," and general singing-dancing and scripture reading, **the jumping, dancing, hand-shaking *dumuna*** is at the heart of the "weighing of the spirit." In this rite a ranking prophet stands with hands trembling in the spirit. Another adherent, whose spirit will be "weighed," evaluated or measured, dances out before the weigher officiant. The weighee extends a hand out to the weigher. If the hand is not grasped, that is if the spirit is not adequate for them to connect, the weighee must confess before the weigher. If the weighee measures up, the hands connect, and the weigher propels the weighee into three leaping handshakes. Three times this routine is repeated, each time the jump more spectacular than the one preceding it. So prominent is this rite that the hilltop center of the Church of the Holy Spirit is called Sala Duma, there where they do *dumuna*.

All of these instances of *dumuna* suggest a crossing over, a transcendent vision of the human condition. The patrifilial blessing, the patrifilial children in turn blessing their father, the weighing of the spirit, and the declaration of an affliction healed, seem to expand the social space around the formerly isolated afflicted one. Further elaboration of this ritual and significations will be offered in chapter 8.

Ritual and Ritualization

Close scrutiny of instances such as *dumuna* allow us to elaborate and theorize on the anthropology of signs in sickness, suffering, disease and healing, and the production and reproduction of health. Our common sense tells us that certain aspects of sickness and healing are ritualized, —life crises and transitions, social dimensions of concern, care and comfort. When we speak of ritualization in connection with sickness, suffering, and healing, we usually mean that special symbols and metaphors are used to mirror, clarify, and express these experiences in wider realms of personhood, society, life and thought that they are not readily dealt with in everyday, conventional terms. The early 20th century anthropologist Arnold Van Gennep gave us the vocabulary of ritual, or rites of passage. It consists of a stage of transition away from an existing social role or status, a stage of transition during which the subject is liminal, in a threshold state; and a third stage, of transition back into society in a new role or status, sometimes that of chronic disease.⁵ This is seen clearly in the case of **a Xhosa igqira in Capetown** at the moment of "entering the white" stage of apprenticeship.

⁵ See J.M. Janzen, *The Social Fabric of Health*, discussion on ritualization, in chapters 5 and 6..

The very notion of "ritual" in anthropological usage has so many possible understandings that one must stake out a claim before using it. The Ethnomedicine Library in Vienna has over fifty books and articles catalogued around the world "ritual," and we know it is a favorite notion of anthropologists. Ethologists love the term; we see how it is defined in a recent encyclopedia.⁶

In ethology, [ritual is] a stereotype that occurs in certain behaviour patterns when these are incorporated into displays. For example, the exaggerated and stylized head toss of the goldeneye drake during courtship is a ritualization of the bathing movement used to wet the feathers; its duration and form have become fixed. Ritualization may make displays clearly recognizable, so ensuring that individuals mate only with members of their own species.

Linguists also love the term ritual. Sherwin Wilcox, a cognitive linguist, uses the term to discuss the acquisition of language in children, and perhaps even historically in human prehistory.⁷

Ritualization is a process that is driven by repetition. A ritualized activity need not ever occur in a social environment. I may, for example, develop a certain ritual for how I shave in the morning; no one affects or is affected by my ritual. Clearly, when we regard ritualization in this way, it is not independent of cognitive abilities such as automaticization. Nevertheless, **ritualization** also can have a significant social aspect. Conventionalization, an important aspect of language is clearly a related phenomenon, a type of socially agreed upon ritual (see also Tomasello 1990, 1994 for a discussion of ontogenetic **ritualization** in the development of chimpanzee gestural signals). Visible gesture ... is a critical raw material on which cognitive abilities and the process of **ritualization** may act. It plays a mediating role in the emergence of language, providing, at different levels and stages of development, various semiotic potentials upon which natural selection may act. My definition of visible gesture is based on an understanding of gesture as action. According to this model, gestures range from the articulations made during the production of language (phonetic gestures which are, for the most part, not visible) to non-symbolic actions which serve only instrumental and not communicative function.

Liturgists also love the term "ritualization," and "ritual," to describe the way they build elaborate worship forms from verbal and nonverbal signs from art, incense, dance, song, choreography, and the uses of light and space. To the extent that I use the term at all here I mean loosely the heightened elaboration of signs and symbols within a social setting or transaction. This understanding of ritualization draws heavily from Gregory Bateson⁸ and Edmund Leach.⁹ They developed a model of ritual seen as amplification of and redundancy around clogged or contradictory channels of communication and idioms of expression. Ritualization in this perspective occurs in highly charged areas of life such as conflict, the difficulty of verbalizing contradictory feelings, or the attempt to maneuver through culturally contradictory values in a single community. One of the problems with ritualization theory is that it suggests there are non-ritualized aspects of life. Yet is it meaningful, or

⁶ <http://www.tiscali.co.uk/reference/encyclopaedia/hutchinson/m0008105.html>

⁷ <http://216.239.53.104/search?q=cache:Aq55m-V5cl8J:www.unm.edu/~wilcox/research/SAR.pdf+ritualization&hl=en&ie=UTF-8>

⁸ Gregory Bateson, *Naven: The culture of the Iatmul people of New Guinea*. Stanford: Stanford University Press, 1958 (2nd edition); *Steps to an Ecology of Mind*. New York: Ballantine Books, 1992.

⁹ Edmund Leach, *Political Systems of Highland Burma: A Study of Kachin Social Structure*. Boston: Beacon Press, 1954; *Culture & Communications, The logic by which symbols are connected*. Cambridge University Press, 1976.

even possible, to speak of human life without signs, perception, expression, articulation? On the other hand, if all of human life is thus ritualized—i.e., a mass of signs endlessly manipulated—does the concept retain any use? Ritual dimensions of sickness and healing, developed into a social sign or semiotic theory, offers a "continuum of signs" that integrates in one holistic perspective the dichotomous disciplinary perspectives commonly, and confusingly, identified as "biology" and "culture." I propose a more seamless semiotic perspective¹⁰ that permits us to understand the construction of human life across realms of experience and cognition that attends the study of suffering and healing in the Kongo setting in particular, and more generally on approaches to the study of ritual in sickness and healing. It is hoped that by privileging the anthropological approach to these issues, we may inspire more adequate research, as well as enhancement of practices in medicine, public health, and health policy.

Representations

Part II of this collection offers the most general lectures that examine popular representations of African health and healing, or scholarly overviews of African healing traditions. In lecture 2-- "Collective Representations of African Health"—Western, specifically American, popular stereotypes about Africa are examined alongside my understanding of how several prominent Africans concerned with health see their healing traditions. This essay compares the two sets of representations, and assesses the vast gulf separating the two. It is based on a lecture that was originally called "Catastrophe Africa: Getting past Stereotypes and Quick Fixes to the Social Reproduction of Health," It explores ways that medical anthropology is put in the service of policy and program review and development. In societies where health improvements are sought through changed behavior, public health interventions presuppose an accurate and appropriate understanding of the bases of human action. North American HIV/AIDS prevention initiatives in Sub-Saharan Africa based on condom promotion and their mostly unsuccessful outcomes are examined in the light of American images about health in Africa. Yet American collective representations of African health, illness, and healing—characterized here as "catastrophe Africa"—have almost nothing in common with Central African ideas and premises on illness misfortune and healing as studied through the categories of divination and several African political leaders who actively engaged in health improvement. American interventions are often overly reliant on technical solutions, individualized agency, and the assumption that African high risk behavior cannot be changed. Recognition of the human, social, and political dimension in Sub-Saharan health, affliction, and healing in case studies of successful health interventions and writings by political leaders on health offers an analytical perspective-- the social reproduction of health-- that can identify the active ingredients of successful African-based health improvement initiatives. Lectures 3-5 present other attempts to provide overviews of African healing traditions. Kongo medicine of Western Equatorial Africa is featured in 3 "Central African Healing Traditions;" "Daybreak in the Heart of Darkness" (chapter 4) offers a picture of public health in early Belgian colonialism; Islamic medicine of Central Sudan is featured in 5 "Sheikhs, Saints, and Baraka," based on a two week visit to Khartoum and vicinity upon invitation of the family of Khalid Elhassan, then my assistant at the Kansas African Studies Center at the University of Kansas.

Reading the Signs

¹⁰ See *The Social Fabric of Health: An Introduction to Medical Anthropology* (McGraw-Hill, 2002), particularly "The transformations of the signs of sickness and healing," pp. 176-182.

Part III "Reading the Signs" generalizes the second Harvard lecture "Central African Sickness and Healing: Reading the Signs."¹¹ I presented the medical anthropologist's perspective as a "reader" of the complex phenomena of sickness and healing. In medical practice and anthropological research alike the signs of sickness and healing—physical signs, symptoms, verbal labels and expressions-- must be read and interpreted within wider realms of personhood, society, and diagnostic ideas of healing traditions. Three projects in "reading the signs" included, 6 "Seeking Experts in Understanding Misfortune and Affliction: Why Divination is so Central to African Healing;" 7 "Etiological Dualism" – agency caused vs. "natural"—in Ebola outbreaks, thus highlighting a widespread etiological paradigm in Central Africa and how it may be "read" in outbreaks of epidemics; 8 "Dumuna" the widespread practice in Kongo society of Lower Congo of associating offices of authority and social harmony and/or conflict with images of sickness and healing; 9 "Ngoma" on song-dance healing seen in the dilemmas or threats of twinship, poisonous vipers, and survival in Apartheid South Africa, three instances of a widespread Sub-Saharan African institution; and 10 "Trauma Healing in Breaking the Cycles of Violence," the post-genocide world and words of individuals from a Rwandan community some of whom survived atrocity at home and others of whom fled into exile. Each of these projects offer a semiotic challenge of how the signs are read and interpreted along a range of themes and levels of intensity and articulation. The semiotic exercise, of course, requires inclusion into one optic of the verbal and nonverbal, the conscious and the unconscious, the metaphysical and physical, and realms of expression and articulation along= the full "sign continuum" as I have proposed.

The Social Reproduction of Health,

In early 20th century Lower Congo crumbling health was associated with the crumbling of authority. The negative effects of the slave trade, associated internecine warfare, the displacement of entire communities during the forced work projects of the Congo Free State, and the forced work projects connected to Belgian colonialism, all eroded the instituted authorities of Lower Congo society. The example of *dumuna* at the close of an investiture ritual (lecture # 8) represents this fusion of the healing ritual of social renewal with the creation of public authority. Some strands of social theory make this same connection between social capital and legitimacy and health. The "production of health" and the "social reproduction—perpetuation of the means—of health" are developed in lectures 8 (on *dumuna*), 9 (on *ngoma* healing networks), and 11 ("Caregiving, therapy management, and power") and 12 (the Social Reproduction of Health).

¹¹ The Vienna lectures expanded on the two Harvard lectures and divided their topics into an undergraduate course with the following headings: 1. An Overview of Central African Medicine: Colonial & Postcolonial Developments; 2. Therapeutic Resources: Definition, Shaping, Usage; 3. Why Divination is so Central to Health and Healing in Sub-Saharan Africa; 4. Ritualization in Sickness and Healing; 5. *Ngoma*, One of Sub-Saharan Africa's Most Widespread Therapeutic Institutions; 6. The Importance of Trauma Healing in Overcoming Cycles of Revenge & Violence; 7. The Social Reproduction of Health.

II. Representations

Chapter 2

CATASTROPHE AFRICA: COLLECTIVE REPRESENTATIONS OF HEALTH¹²

The Western image of health (or disease) in Africa—caricatured as the sick continent—stands in sharp contrast to the African understanding of disease and misfortune as I have come to understand it in the places I know best: Kongo society of Western Equatorial Africa, and certain regions of the Southern Savanna, East and Southern Africa. The Western image of Africa reflects the sordid history of slaving, imperialism, popular culture, and an un-ending parade of televised depictions of wars, starvation, disease, and misery, coupled with a faint romantic construction of a distant “other” that is at once primitive, sometimes noble, and always exotic. The African side of this view is more complex and distinctive. It too looks at disease in relation to the human community, it too is richly diverse, and historically evolving, but at great odds with the Western image.

In order to rigorously compare and contrast this “myth” of Africa, in which disease is a central theme, with the popular Central African understanding of disease and misfortune, I introduce related notions of “collective representation” and “social fact”¹³ from Emile Durkheim and Marcel Mauss, French social theorists for whom the organization of reality is mirrored in, and affected by, the social order. Levi-Strauss, in his far-ranging studies of myth, continued to use this general perspective that reality and society were articulated together, and that contours and transformations within the one order were reflected and sometimes presaged in the other.

The equivalence, hence the comparability, of American and Central African images of sickness, health, and healing in the latter setting may be questioned. Whereas the African version of this reality is like a mirror held up to view oneself as individual, community, or subcontinent, the American version is

¹² Originally entitled “Catastrophe Africa: Getting Past Stereotypes and Quick Fixes to the Social Reproduction of Health,” this chapter is adapted and revised from presentations at the first session of the University of the University of Kansas African Studies Fall 2003 Seminar Series “Health disasters and the future of health in Africa” September 23, 2003, and a February 26, 2004 lecture to the seminar series of the Center for Population & Development Studies, Harvard University. In this second of two papers for the Working Group on “Health, Healing, and Ritual Action” of the Harvard Africa Initiative, medical anthropology is put in the service of policy and program review and development. Several of these topics originally put together are developed as separate chapters here. The present writing highlights the often incompatible collective representations of Western and African images of health. In societies where health improvements are sought through changed behavior, public health interventions presuppose an accurate and appropriate understanding of the bases of human action. North American HIV/AIDS prevention initiatives in Sub-Saharan Africa based on condom promotion and their mostly unsuccessful outcomes are examined in the light of American images about health in Africa. Yet American collective representations of African health, illness, and healing—characterized as “catastrophe Africa”—have almost nothing in common with Central African ideas and premises on illness misfortune and healing as studied through the categories of divination and several African political leaders who actively engaged in health improvement. American interventions are often overly reliant on technical solutions, individualized agency, and the assumption that African high risk behavior cannot be changed. Recognition of the human, social, and political dimension in Sub-Saharan health, affliction, and healing in case studies of successful health interventions and writings by political leaders on health offers an analytical perspective-- the social reproduction of health-- that can identify the active ingredients of successful African-based health improvement initiatives.

¹³ In his Introduction to the collected work of Marcel Mauss, which in turn incorporates major features of the work of Durkheim, Levi-Strauss writes of the Durkheimian and Maussian approach that it seeks to “définir le social comme la réalité,” (p. xxv), and again that the “fait social total” is at once sociological, historical, and physio-psychological (Claude Levi-Strauss, in “Introduction a l’Oeuvre de Marcel Mauss.” Marcel Mauss, *Sociologie et Anthropologie* (Paris: Presses Universitaires de France, 1960).

decidedly of the other, and has many of the qualities of myth. That is, it is full of simplifications and stereotypes.¹⁴

The relationship of the social order and the collective representations in Central African to the North (or Euro-) American construction of African health and disease should be of great interest not just to anthropologists and Africanists, but also to scholars, planners and coordinators of health programs. Constructs of the other, in sickness and health, are at the basis of development policies and initiatives, and it is important that they be reasonably “right” if such programs are to succeed. One of the Western initiatives that apparently lacked this congruence between the collective representation of the “other” and the basis of health-related behavior, was the American campaign for HIV/AIDS prevention in Africa, based largely on condom promotion. The roots of such a mistaken collective representation need to be problematized, critiqued, and corrected. But additionally, the distinctive African approaches to misfortune, disease, and healing need to be understood in all their social rootedness, their variations, and unfolding nuances. A more sophisticated grasp of African approaches to disease, health, and healing in their social contexts is essential in successfully addressing some of the most awesome health issues of our time.

Sickness in the Western Image of "The African"

Sickness is a major dimension in the Western “collective representation” of Africa that many teachers and scholars have spoken of as the “myth of Africa.” The myth variously depicts Africa as exotic, remote, violent, backward, diseased, strangely a-historical and homogeneous, one people (or a bunch of tribes), nation, or place, one geography.¹⁵ This is a modern myth that remains entrenched in the collective consciousness and popular culture, despite efforts by educators and others to deconstruct it and displace it with a more nuanced imagination. If Levi-Strauss is right, then the myth of Africa in its many and varied manifestations is a narrative of reality that makes order out of chaos, a safe zone out of threat, by reducing to simple binary oppositions (e.g., us/them, here/remote, civilized/savage, domestic wild) the cultural space that Africa occupies. Elements of the myth are constantly reconstituted around its basic structure, demonstrating its rootedness in social relations and reality.¹⁶

The origin and persistence of the myth of Africa has perplexed and challenged scholars. **Dr. Nema Blyden** of the University of Texas at Dallas, one of several professors who teach seminars on the image of Africa, writes about its origin:¹⁷

¹⁴ My original delivery of this paper to a student and faculty audience at the University of Kansas alluded to the myth of Africa as a point of departure for a discussion of health initiatives in Africa because I knew, from my experience at that large public university in the American heartland, that the image of Africa in the minds of many Americans is like a “myth of Africa”—overly simplified, full of seemingly ineradicable stereotypes that reappear in each new student generation. Students like these went on to work in a range of settings, including public health. In wide reading I saw resemblances of the “myth of Africa” to some of the premises in public health initiatives coming from the U.S.

¹⁵ "If It's Africa, This Must be a Tribe." *Africa News* 33(1987), 10, p. 13.; Paul Bohannan and Philip Curtin, *Africa and Africans*, 1988 (3rd ed.) make this point in their first chapter, "The myth and the fact."; Sheila Walker, "Tarzan in the Classroom: How 'Educational' Films Mythologize Africa and Miseducate Americans," *J. of Negro Education*, 62 (1993), 1, pp. 3-23; N. Frank Ukadike, "Western Film Images of Africa: Genealogy of an Ideological Formulation," *The Black Scholar*, 21 (March, 1990), 2, pp. 30-48.

¹⁶ Claude Levi-Strauss, *Myth and Meaning*. Toronto, 1979.

¹⁷ Blyden's course “The Invention of Africa” focuses on such works as Richard Burton's *Wanderings in West Africa*; Joseph Conrad's *Heart of Darkness*; Philip Curtin's *Image of Africa*; Leo Hansberry, *Africa and Africans as seen by Classical writers*; Eldred Jones, *Elizabethan image of Africa*; Mary Kingsley, *Travels in West Africa*; Peter Mark, *Africans in European Eyes: The portrayal of black Africans in 14th and 15th century Europe*; Colin McEvedy, *The Penguin Atlas of*

For a long time the image, or imagined state of Africa, determined how Westerners wrote about that continent. Ignorance of the African continent in the period before European contact led many Westerners to portray Africa in various ways. Such images included representations of Africa as a land of exoticism, a land of great riches, the "Dark Continent" and a place of savagery. Once Europe came into contact with Africa, did these images change?

Dr. Blyden stresses contacts between Africa and the West, with particular emphasis on the changing views and representations of Africa that Westerners held. Ethnocentrism, cultural bias, economic motivation, racism and religion were its sources.

Nigerian writer **Chinua Achebe** has explored the negative aspect of Western images of Africa. His primary data are his own personal experiences in America, questions people ask him about Africa, as well as literary works. Joseph Conrad's *Heart of Darkness* has intrigued him as one of the most significant pieces of Western literature in shaping the image of Africa. He argues that its reason for success as Western literature is that it reflects a late 19th century image that continuing today, because it reinforces the myth.¹⁸

Heart of Darkness projects the image of Africa as "the other world," the antithesis of Europe and therefore of civilization, a place where man's vaunted intelligence and refinement are finally mocked by triumphant bestiality. The book opens on the River Thames, tranquil, resting, peacefully "at the decline of day after ages of good service done to the race that peopled its banks." But the actual story will take place on the River Congo, the very antithesis of the Thames. The River Congo is quite decidedly not a River Emeritus. It has rendered no service and enjoys no old-age pension. We are told that "Going up that river was like traveling back to the earliest beginnings of the world."

Mahamat Saleh Haroun, Chadian filmmaker, notes that the negative stereotype of Africa is promoted by Western film directors' use of Africa as a backdrop. He singles out George Lucas for his uses of North African desert as the setting for his scenes—e.g., the planet Tatooine in the "Star Wars" series 1977, 1999, and 2002.¹⁹

Africa is just a location for Star Wars, for alien plants, for animals, rather than a place where there are human beings. This is causing a reiteration of negative stereotypes, "Around the world, people get the wrong image of Africa through movies because African actors are just dancing and laughing with big teeth. It's the fault of the directors and their vision about Africa. It's like the Garden of Eden, or a location just for animals..."

If Blyden, Achebe, and Harom are right, then such persistent association of Africa with stereotypes of violence, disease, and exoticism reinforces the Western view of ourselves, the opposite of which is Africa.

In my teaching of introductory courses on Africa, for some years I surveyed the class in the first session asking for unreflective word associations with the topic of the class, "Africa." The key words that proved consistently most common included "native," "hut," "jungle," "remote," "tribe," "savage/primitive," "wild animals," "diseased/ sick/ dangerous." The elements of the myth of Africa, demonstrated in student writing and essay answers may be captured in a number of words or phrases, as

African History; Jan Pieterse, *White on Black: Images of Africa and blacks in Western Popular Culture*. For course URL, see: <http://utdallas.edu/~nblyden/f99hst4305.html>

¹⁸ <http://social.chass.ncsu.edu/wyrick/debclass/achcon.htm>

¹⁹ <http://news.bbc.co.uk/2/hi/africa/2805999.stm>

follows: Africa is one country, one people, whose inhabitants speak one language, “African”; Africa is timeless, it has no history, reflected in student generalizations; Africa is remote, it doesn’t relate to me, I have no connection to it; It is exotic, one of the main reasons for taking the course; but it is also violent, sexual, primitive, dark, and finally, sick.

Images of “sick Africa” appear regularly in the mainstream Western media. As if to oblige me, the *New York Times* ran a story the day before my lecture in September, 2003, about a local region in Southern Sudan where about a hundred children suffer from a neurological disorder that causes nodding, loss of growth, and listlessness.²⁰ Yet the *Times* ran a full-page feature article on this disease, as if that’s what is newsworthy about the Sudan. All the predictable adjectives of the myth of Africa are there:

- “mysterious” disease; in a
- “remote” region;
- “even more desperate people who live in even more remote places”
- “trek here for treatment”
- “jungle village”, with
- “mud huts,”
- “pinned in on all sides by lush growth...”
- “the sickest place on earth.”

This story has all kinds of sub-texts, not the least of which is to document and certify the bravery of the reporter, who made it all the way to southern Sudan and showed her colors by documenting a rare disease. To make it in Africa, reporters need to penetrate the remote and exotic other. This story may be journalistically appropriate, but what is wrong with it is that it fuels the mythic construction of Africa as exotic, remote, miserable, mysterious, disease-ridden sickest place on earth, and that this is somehow characteristic of the whole of Africa, which, in the myth, is one society, one nation, one place, one homogeneous population.

To offset the myth, which presents the continent of Africa as one homogeneous whole, even one country, without change or history, every literary, historical, diplomatic, or whatever venture, including health, must take into account the following fairly obvious truths. Africa is a continent with over 50 countries, sovereign states, only a few of which are “collapsed”, or have wars, and tend to get all the media attention. The people of the African continent speak languages from five distinct language families that have no recognizable historical relationship in the past 5,000 years. yet often references to Africa are racialized, somehow, whose existence is seen mainly as an extension of African-American identity. Geographically, Africa is a range of environments and multiple adaptive ways, including pastoralists, farmers, and city dwellers. The populace of the continent includes both beggars and billionaires. Africa, the “sick continent,” reflects a range and variation of disease rates, including countries such as Zambia and Botswana where the HIV+ rate of infection in birthing mothers is at 35%, and others, such as Uganda, where dramatic intervention has brought the rate down to ca 5-6%, or

²⁰ Marci Lacey, “Sudan’s Luckless Children, Locked in Land of Nod.” *New York Times*, Monday, September 22, 2003, describes a rare neurological disorder in the southern Sudan region of Lui in which sufferers nod off to sleep--a form of sleeping sickness?

Senegal where it has never risen above ca. 1%, and where public officials, religious leaders, and educators are carefully monitoring the situation before it gets out of hand.

As I have learned from years of teaching introductory courses on Africa, deconstructing the myth of Africa through emphasis on variations is only partially successful, with the best students. Some in every class succeed somehow in reconstructing the course material to fit the myth. The media, movies, and the classroom are not the only areas in which the myth of Africa have persisted. As noted in the introduction, I am particularly interested in its lingering presence in the health policies. The homogeneity of Africa, as well as other elements of the myth, would appear to have seeped into HIV/AIDS prevention programs launched in America.

HIV/AIDS Campaigns & the Myth of Africa

I single out for brief examination the campaign that promoted condoms as the main strategy of HIV/AIDS prevention by North American agencies, in particular those by USAID. In stark contrast to this story is the emergence of African national campaigns, the case of Uganda being the most spectacular, that were launched on quite different conceptual foundations and which have demonstrated measurable successes. I am particularly interested in whether, and how, the condom campaign fits within the above-elucidated Western myth of Africa. Second to that, I am interested in the bases of the successful Uganda AIDS prevention campaign. Recent evaluations of condom promotion as the kingpin of Western AIDS prevention in Africa²¹ offer insight into why condom use was peddled so single mindedly, and why the results have been less than impressive. ? According to Green's recent *Rethinking AIDS Prevention*, the U.S. program for HIV prevention in Africa was couched within the dual settings of the reproductive health and family planning initiatives, and the responses to the HIV/AIDS epidemic among the high risk groups of gay men and female sex workers in the U.S. Reproductive and sexual rights were held to be nearly sacrosanct in these programs. Condoms promotion was seen as the only way to assure sexual rights of these individual while preventing risky behavior. Therefore condom distribution and "behavior change" to learn to use them were chosen to combat the African epidemic. American experience was considered to be the valid basis for the African initiative. But there was another dimension to the story that was apparently ignored, namely the perception of African sexuality, the body and society.

Green elaborates at length on why condoms were privileged. I will abstract from his story what I perceive to be elements of the myth of Africa at work here. First, the technological fix on condoms (and medications) was adopted because, in the American perception, it seemed to be the most straightforward and simplest way to solve "the problem."²² Given the high cost of drugs, this meant that condoms were often the only piece seen by the targeted groups: prostitutes, truck drivers, and the general sexually active public. Condoms also were useful because they avoided workers having to become judgmental of others' sexual practices. Moralizing, it was thought, would alienate the very people one wanted to reach.

²¹ Edward C. Green, *Rethinking AIDS Prevention: Learning from Successes in Developing Countries* (Westport CT: Praeger, 2003); Norman Hearst & Sanny Chen, "Condom Promotion for AIDS Prevention in the Developing World: Is it Working?" *Studies in Family Planning* Vol 35, 1 (March 2004), 39-47.

²² Green's Chapter 3, "Behavior Change and the Problem of Ethnocentrism."

Green situates this American liberalism of wanting to avoid judgment of African sexual practices within one of the elements of the myth of Africa that makes us all most uncomfortable, namely the idea that Africans are hypersexual. Since the days of the books by French army doctors in Africa, this part of the myth has been raised repeatedly. Green quotes Western health workers in Africa saying what was on many minds back home as an unspoken truth: Africans, like American gay men and teenage boys, could not be expected to change their sexual behavior. Condoms were the only way their danger to others could be limited.

Mythic elements surfaced at other points in Green's account. Even his fellow anthropologists were horrified that he called into question the condom campaign because of widespread reports of condom failure rates, and infection increases among those relying on condoms, compared to those who were delaying first sex, and limiting partners, without condoms. He laments that he was identified with the "abstinence only" religious right. This polarization of "condoms vs. abstinence" reflects the mythic dualism spoken of by Levi-Strauss that emerges in an chaotic, emotionally charged realm of life.

Uganda's "ABC" program has now become legendary for its remarkable success in bringing HIV/AIDS infection rates down from over 20% of the population in 1991 (the highest in the world at that time) to 6% in 2000.²³ This national program, based primarily on abstinence (A = the deferral of first sexual relations among youth), limiting sexual partners (B= "Be faithful," "zero grazing" outside of marriage or committed relationship), and thirdly, if the first two are not possible, sex with condoms (C). Analysts who have studied the early years of this program in the late 1980s, and have compared it with other programs, have begun to identify the major reasons for its success.²⁴ The leadership, outspokenness, and insistence on transparency by President Yoweru Museveni is recognized by all as important. The removal of stigma from AIDS sufferers was important in permitting those who were infected to be honest about their condition, and those who related to them to work out methods of not transmitting the infection. The engagement of religious leaders was also important in bringing issues related to HIV/AIDS into the forefront of national consciousness. The broad multi-sectorial involvement of over 700 organizations, ministries, and NGOs demonstrated that this was a single-minded national priority. Thirdly, observers identify the participation of the schools extremely important in the transformation of sexual attitudes and behaviors among students and young adults. From 1987 on general sex and focused HIV education were carried out in primary schools, leading to a rapid decline of infection rates in the 14-25 year age group. A fourth reason noted for the success of Uganda's HIV/AIDS reduction program was that promoted the empowerment of women and youth, everywhere the principal victims of rampant AIDS epidemics.²⁵ Other features of the Uganda approach included the training of healers in AIDS prevention education and palliative treatment, and generally the open discussion of the issues facing the nation.

One feature in the Uganda program that scholars and AIDS prevention promoters have noted with considerable ambivalence is the use by the government, in its publicity campaigns, of "fear arousal."²⁶ The close association of AIDS with death and the outright use of scare tactics in public and school education has been simultaneously criticized and grudgingly admitted to be an important reason for the program's success.

²³ Green, *Rethinking AIDS Prevention*, p.143.

²⁴ Green, *Rethinking AIDS Prevention*, see especially Ch. 6, "What Can We Learn from Uganda?" pp. 141-226; Hearst and Chen, *op. cit.*, p. 42.

²⁵ Green, *Rethinking AIDS*, pp. 169 ff.

²⁶ Green, *Rethinking AIDS*, p. 178 ff.

Observers of the Uganda AIDS prevention program note a number of features that it has in common with that in Thailand, the most successful program in Asia. Both countries “responded to AIDS early and decisively. Both . . . had leadership from the highest levels, were multisectorial, achieved broad public support, avoided stigmatization, and included care for the infected.”²⁷ The two programs differed significantly in other details. Thailand aggressively promoted condom use in controlling infection among the high-risk communities of sex workers, whereas in Uganda the focus was the broad-based student and young adult at risk sectors of society, without the promotion of condoms.

In many ways, therefore, the Uganda AIDS prevention campaign is to be explained by that country’s unique experience. This included recovery from yet vivid memory of the dictatorial regimes of Amin and Obote; civil war, loss of many lives, and no doubt central to its effectiveness the force and candor of President Museveni’s personal engagement in the campaign at a time when he was rebuilding a shattered country with many well-educated people given the opportunity to be of help. The story has to do with a gamut of issues that are more than just technical or behavioral, but include social, political, cultural and moral dimensions. The broad base of Uganda’s AIDS prevention campaign, by contrast, casts the American condom-centered approach as a pathetically narrow “techno-fix” that simply ignored what it might take to truly engage the issues at stake, and move in concert with the local community and nation at the most pervasive level.

Central African Collective Representations of Sickness & Healing

The articulation of “collective representations” and “social facts” of disease, sickness, and healing in Central Africa are nowhere more clearly evident than in the determination of the causes of misfortune, or in the terms kinsfolk use to discuss the misfortune of a loved one in their midst. A closer look at the categories, criteria, and discernment procedures used will serve as a shorthand for this discussion of how Central Africans see sickness and healing.

The pervasiveness of divination in Central Africa attests to the perceived importance of the causation of affliction. This is particularly true in those cases in which the sequence of layered intervening causes are seen to shift from a mundane material cause to a highly charged human or spirit cause. Usually consultation with a diviner is not undertaken until there is sufficient reason in the kin group of the sufferer to suspect causes other than natural ones. Such a precipitating factor may be the worsening turn of a sick person, a sudden and mysterious death, the coincidence of a sickness with a conflict in the close social environment of the sufferer, or the paradoxical occurrence of a disease on only one side of a family. In such cases the clients are looking for answers to questions not only of “Why did it happen?” but “Why did it happen to us?” What brought about this conjuncture of material and social causes? And possibly “Who caused it?” and “What should we do about it?” Scientific explanations of disease do not usually lay to rest these questions, which are of a different order from the ideas in natural causation, both the traditional type of “just happened” and modern scientific “isolated single causal factor.” A community may know very well that the spirochete transmitted by the bite of an anopheles mosquito causes malaria in the blood of a human. But the diviner may shed light on the question of why some people are infected and not others, or why some died when all were infected. Divination may also clarify the human causes behind accidents or provide a pattern with which to explain them.

²⁷ Hearst & Chen, *op. cit.*, p. 43.

Western medicine is often good at answering “why?” but not “why me?” or “why me and not my sister?”

In later lectures I will go into great depth on the particular kinds of divination that are widespread in regions of Central Africa, and of the varied ways that scholars have studied the culture and assumptions behind the widespread use of divination to determine the above questions. For present purposes it suffices to note that some of the techniques, such as the Ife basket of Nigeria, or the Ngombe basket of the Southern Savanna, or the throwing of bones in Southern Africa, may well be hundreds of years old. But the questions that they channel are ever upgraded.

These and many other types of divination in Sub-Saharan Africa are predicated on the assumption that sickness or other misfortunes may be caused by an untoward turn of events in the human or related spirit world. The immediate cause or agent such as the sign or symptom of disease is thought to require interpretation in the light of ultimate natural, human or spirit agents. Thus, despite widespread acceptance of modern science, divination continues to be a common method for discerning the dividing line between that which “just happens” and the human or mystical factor that is seen as important in the moral universe of misfortune.

No doubt public health advocates will respond to these lines that they do not have time to get acquainted with local diviners or the public’s diagnostic efforts when epidemics are raging and people are dying. In subsequent lectures we will take up the attempts by public health experts, physicians, and some anthropologists to come to terms with recent ebola outbreaks in Congo-Brazzaville. Although many health educators went out of their way to explain the viral nature of ebola, popular understanding continued to consider it the work of sorcery by malign persons, politicians seeking power, whitemen in the region, and even the health authorities themselves. A better understanding of the relationship of knowledge to social control (or lack of control) is needed to come to terms with these emergency situations. It is wrong to read the classificatory contrast of “natural” to “agency-caused” as somehow fixed with regard to types of afflictions and diseases. The dichotomy shifts depending on the social circumstances. If classical divination seems too arcane and time-consuming for public health, then we may look through the eyes of educated elites, policy makers, and political leaders –or at least the more sensitive– where the same issues are taken into account. They demonstrate the vital role of power and authority in health initiatives.

**Kusikila, Rwanganbo, & Mbeki:
The Intelligensia & the Powerful on Sickness and Healing**

¹⁰ Anyone who has studied sickness and healing in a Sub-Saharan community will understand these questions and discussions. My understanding of these issues were first published in *The Quest for Therapy in Lower Zaire* (California, 1978) and in later publications on therapy management groups. A long series of useful publications have appeared on African disease causation, cursorily reviewed below. These lines, and much of this section, are adapted from a recent chapter by myself and Edward C. Green, “Continuity, Change, and Challenge in African Medicine,” (pp. 1-26) in Helin Selin, ed., *Medicine Across Cultures: History and Practice of Medicine in Non-Western Cultures*. Dordrecht: Kluwer Academic Publishers, 2003.

The cases of Aristotle and Alexander the Great in ancient Greece and Ibn Khaldūn and the sultans of 15th century North Africa should give us pause when we advocate scholarly models for the pragmatic needs of rulers. Yet, nowhere is the combination of knowledge, wisdom and power more crucial than in the promotion of public health. Since it is unlikely that the NGOs and foreign ministries of the world will soon pay attention to Central African diviners, I present three cases of political leaders who articulated the same health issues as those raised by therapy managing groups and diviners. The fundamental question addressed by the diviners-- When is affliction in the natural order of things, or when is it unnatural? Is it “of God” or “of man”?—are above all social questions, or questions of misfortune that relate to social facts, as Durkheim, Mauss, and Levi-Strauss understood so well.

Kongo ruler/writer **Kusikila kwa Kilombo** was a former teacher and two-term immediate postcolonial mayor from the Kivunda commune in the Manianga region of the Lower Congo. I lived in his house during my earliest fieldwork in Kongo society, and appreciated many long and thoughtful discussions over issues I encountered in my research. I knew he had to deal with many problems and tensions within the community he ruled, not the least of which were frustrations over the way that the national government turned into a worse oppressor than the colonial government. His understanding of Kongo society was the most sophisticated I encountered, because he not only could give me the standard explanations of events and issues, he developed original theories that often reflected his wide reading. But most of all he was wise from experience and could theorize his experience. I found his views on power most interesting because he tied them to *kindoki* --what people called witchcraft – on the one hand, and to sickness and healing on the other. He understood *kindoki* to be the ability of a person to influence and affect others, for good or for ill, an understanding close to the classical meaning of the proto-Bantu term *loka*, the root of *kindoki*, the power of words. Chiefs, elected mayors and presidents, enjoyed legitimate *kindoki*, and needed it to govern, whereas what most people called witches, sorcerers, or *bandoki*, were those who used *loka* in an antisocial, illegitimate, manner. The latter was what people feared.. People who had grown up in colonialism did not know what legitimate power was, or looked like, but in Kusikila’s understanding it was made up of persons like himself, duly elected, exercising power for the good of society.

It was in this rubric that Kusikila told me of his experimentations with communities where dissension and chaos reigned, and people were sick. In one such situation he had told the community to clean up their houses and streets by his deadline, or else he would imprison them. Their complaining stopped, as did their sickness. They became his strong supporters. He had used his positive *kindoki* for the well-being of this community.

During my fieldwork Kusikila wrote a treatise entitled *Lufwa evo Kimongi e?*²⁴ *Lufwa* is the straightforward Kikongo term for death. *Kimongi*, on the other hand, is translated as pestilence, or foreign or strange death. The two words represent the two opposing poles of the diviner’s dichotomy, whether an affliction is “of God,” or “of man.” However the framework is broader than that of most diviners. Kusikila’s describes all the causes of *kimongi*, the strange, unnatural death. Adultery leads to broken homes, sexually transmitted diseases, infertility, and a declining birth rate; Parental ignorance leads to sick children; malice leads to diseases that cannot be treated by medicines. Although there are literal poisons that kill people, metaphorical poisons are more pervasive and injurious—e.g., wrong instructions in schools, certain kinds of study abroad that turn the youth away from their home country,

24 Yoswe Kusikila kwa Kilombo. *Lufwa evo Kimongyi e?* Kinkhimba kia Kongo. 1969. Translated as “Death or Pestilence, which?” in *Anthology of Kongo Religion*, J.M.Janzen & W. MacGaffey, eds., 1974.

the shunning of agriculture, wanting to be like Europeans, and abandonment of one's language. Breaking oaths leads to loss of trust in institutions like courts, economic contracts, and civil servants. The reliance on magic (from Europe) or the lust after easy riches and theft, instead of work, leads to a kind of craziness. Slavery and colonial forced labor led to a loss of well-being and a distaste for work. Finally he comes to witchcraft, where he develops his theory of legitimate and illegitimate power. A country must develop in the vision of its true nature to prosper. Each country has its roots where it must find its future. He closes with a call to enlightenment, to build on science and leadership, to escape the reign of "pestilence."

The late Rwandan scholar, physician, and politician **Pierre-Claver Rwangabo** provides insight into the nature of affliction and society in contemporary Great Lakes African thinking. Although I met him once briefly in the southern Rwandan university town of Butare in 1995 where he was governor, the main source of my comments here is his 1993 book *La médecine traditionnelle au Rwanda*.²⁵ The title of his book underrates the tone of his argument. Writing as a university-educated physician, Rwangabo argues that Rwandan medical knowledge is a part of contemporary reality rather than a cultural fossil. This gives his insight into African medicine the remarkable cast of a modern, scientifically informed, traditional-historical set of ideas, roles, and practices.

Rwangabo classifies the etiological domains of affliction and healing into "physical" and "mystical" causes. Diseases range across a variety of types which may be attributed to either or both causal category, a feature would be regarded as unacceptable in a Western Linnean -derived classificatory taxonomy, yet is absolutely right for the Central African universe of misfortune etiological attribution. Rwangabo's medical training is evident in his listing of disease classes that include: parasitic diseases, microbial diseases, systemic diseases and bodily accidents, gynecological and obstetrical diseases, and psycho-mental and behavioral diseases. This classification appears to correspond to the WHO's International Classification of Diseases. But under the latter group he identifies current psychopathologies that entail abnormal behavior as understood in traditional thought and diseases believed to be caused by broken prohibitions and beliefs about ancestors (*abazimu*) and other spirits (*ibitega, amahembe, nyabingi, amashitani, amajini*) which often are identified in relation to mental illnesses. "Poisoning", the result of human aggression, is a major aspect of the human source of misfortune. Misfortunes brought on by the breach of social rules also have a mystical though not necessarily mysterious causal character.

Rwangabo's insight into the character of traditional medicine lies in the already-noted observation that most pathologies may have both a physical and a mystical dimension. This affects the way therapy will be arranged. The decision to seek physical or other therapy has to do with the context in which it occurs, its severity, the suspected human dimension, and response to treatment.

This emphasis on the context of the causal attribution makes all the difference in how sufferers, their therapy managers, diviners, healers and medical practitioners will treat illness. If the misfortune is considered to be ordinary and predictable, it will be seen along the lines of the material world. If catastrophic forces or circumstances have precipitated it, or if it seems to be the result of the chaos of underlying affairs in the human and mystical realm, it must be handled differently. Thus the same condition may need to be treated with different medicines. Furthermore, these broader causes must be dealt with before or concurrently with, the more focused physical symptoms.

25 Pierre-Claver Rwangabo, *La médecine traditionnelle au Rwanda*. Paris: Karthala, 1993.

Rwangabo's sociopolitical environment was very much a place in which poisons, spirits, and dangers inhabited the physical realm. Although he had been a very diligent member of the medical faculty of the national university, and a leading researcher in the Butare-based institute for African medicine. Because of his moderate views and high reputation the new Rwandan Popular Front government that won the war in 1994 asked him, as a Hutu intellectual and physician, to join it as governor of Butare, one of 12 provinces. Under his leadership this region that had been terribly ravaged by conflict, and still in early 1995 held large internal camps of displaced persons, to a modicum of peace by early 1995. His leadership and his intellectual genius were snuffed out in an instant in February of 1995 when he and part of his family and staff were assassinated on a return trip from Kigali. To my knowledge this crime has never been solved. Speculation is that he was targeted by radical Hutu who resented his working with the "Tutsi" government, or by elements within the government who disliked his criticism of human rights abuses by the new regime. Whatever the causes of his untimely and tragic death, Rwangabo contributed greatly to etching a model of the physician-scholar-public servant who understood how to bring high legitimacy and the authority of his person and office to bear on resolving public problems.

South African President **Thabo Mbeki** is the third illustration of intelligensia and power broker who deals with health issues. His association with HIV/AIDS has brought him a degree of notoriety in the eyes and opinions of the international medical community. Particularly outrage was voiced over his comments at international conferences that there is no proof that HIV causes the varied and opportunistic infections and diseases that afflict and kill those who are HIV positive.²⁶ Less controversial was his argument, made in various times and places, that HIV/AIDS is caused by poverty. Taken in terms of the then-current scientific wisdom about HIV and AIDS, the first statement was regarded as adhering to a dissident research community headed by two U.S. scientists, Peter Duesberg and David Rasnick, who denied outright that HIV causes AIDS.

Less controversial was his argument, made in various times and places, that HIV/AIDS was caused by poverty. Reading Mbeki's full comments more carefully, in light of the second comment, there is much, much more to the story, in dimensions that cast the South African government's response in the light of the African social and political context commented on earlier.

By 1992 Mbeki had come around to accepting the scientific community's view on the link between HIV and AIDS. However, the resistance to full acceptance of this notion contained more than the mere issue of causality. At stake was the question of whether the full medicalization of a terrible scourge was going to be permitted as official policy, in tandem with a corresponding de-politicization of the question of causality. Clearly Mbeki and his circle did not want to allow this, because that would be seen as a retreat from some of the core ideals in the ANC South African circle that had staked its future on the promise to improve living and economic conditions for all South Africans. **[Mbeki: rich and poor-sick]** There was more. There was a reluctance to accept the West's template for treatment, including condoms and AZT drugs. These approaches, seen to emerge from the U.S. profile of AIDS sufferers—mainly male homosexuals and female prostitutes-- were seen as not fitting the prevailing African situation of heterosexual and mother-to-child infections. In other words, Mbeki's words

26 Maggie Fox, "Scientists call S. Africa's AIDS policy idiotic," Reuters News Service, Washington D.C. n.d. <http://www.blancmange.net/tmh/articles/maggiefox.html>

harbor a resistance to the West's stigma for Africa. Perhaps this resistance also included some continuing denial of the scope of the problem. In any event, Mbeki argued that Africa's AIDS profile and problem was uniquely African, therefore it required uniquely African approaches. Essentially, reading his remarks entitled "HIV=AIDS Controversy: What's all this Then?" in 2000,²⁷ he is able to show the very substantial program that his government has launched and how the South African initiatives are distinctive to the problem. This would include his government's spear-heading the global economic-legal initiative to embarrass the large northern pharmaceutical companies to release patent rights for the generic reproduction of drugs.

Mbeki's rhetoric and his actions may be summarized in a few sentences. Yes, we have a serious problem, but don't cram your Western solutions down our throats and insult our intelligence. Our situation is unique. AIDS in the West is mainly a homosexual disease, here it is not. You are rich and can afford AZT treatment. We have many poor with HIV/AIDS, who are dying of opportunistic diseases such as TB. Part of our campaign will be to make possible cheap generic drugs, as well as continuing to campaign for all kinds of preventative efforts. We will deal with this scourge in our way, and will not relinquish our authority to Western NGOs, drug companies, and governments. He would spear-head the campaign to free some of the AZT retroviral drugs from drug companies. In each of three cases the political leader engaged political capital and personal prestige toward the broad public resolution of a major problem. Sickness was healed in a manner of speaking by asserting political will, together of course with technical expertise, resources, and great legitimacy. We may well add Museveni's engagement for the ABC program in Uganda to this set of examples from Central and Southern Africa.

Conclusion

At the outset of this paper I set forth to compare and contrast the American with the Central African versions of collective representations of African sickness, health and healing. The largely negative Western stereotypes bear virtually no resemblance to the efficacious African initiatives exemplified by the work of the three leaders (or four, if we include Museveni and the Ugandan ABC program of HIV/AIDS prevention). What is invariably missing from the Western collective representation is the significance of the social context and the political will that are central in the African counterparts. Why is the social and political dimension missing from Western assistance models? One answer may be the preoccupation with technical quick fixes and the condescension with which African counterparts are regarded. Another may be that Western agencies very rarely have a good grasp of African thought about health, misfortune, and healing, and thus fail to consider the African cultural and social infrastructure as part of the solution. These and other examples will be examined in the lecture 9 of this set.

27 Thabo Mbeki, "HIV=AIDS Controversy: What's All this Then?" Letter to AIDS in Africa world leaders, April 3, 2000. <http://www.blancmange.net/tmh/articles/mbeki.shtml>

Chapter 3

CENTRAL AFRICAN HEALING TRADITIONS: COLONIAL & POSTCOLONIAL PERSPECTIVES ²⁸

Overviews of Sub-Saharan African health, sickness, and healing often have the flavor of a general stew that includes a little bit of everything, and not much of anything. In this opening lecture that sets the stage for subsequent sessions, I propose to look at colonial and postcolonial changes in the medicine traditions that we commonly designate as African derived, that is not having to do primarily with imported Western medicine. I will focus primarily on Central Africa, [**Zablon's orthopedic clinic, Lower Congo**] that is the Congo Basin that stretches from Matadi to Bukavu. A larger scope of my discussion will allude to the Bantu-speaking world that provides us with a cultural and linguistic frame of reference especially useful for the understanding of verbal concepts relating to health, sickness, and healing.

Colonial and postcolonial changes in health, sickness, and healing were dramatic, although perhaps they were merely the continuing changes of the precolonial era. Loss of authority of the practices and beliefs related to them were common. Repression of revered healers and imposition of alien ways; imposed work routines; new religion—were all major changes that affected the way medicine was done. In the postcolonial era changes have been as dramatic, with massive urbanization in many regions, often coming in the time of war and displacement. Central African societies have become globalized. Many families live in multiple countries. The ravages of war and of new epidemics have affected many people, and the outlook of their ways of dealing with them. Western scientific perspectives have been promoted, and have been used to influence and perfect African medicine. The line between “African” and “Western” or “cosmopolitan” has blurred, if not become altogether unclear.

Still, there are perspectives, ideas, and practices that continue to be identifiable within the broad stream of African healing. These are still visible when one takes the deep, or long-duree view of history. Sub-Saharan African realities relating to health, sickness, and healing have evolved over three millennia in constant interchange with those of other world regions, particularly of the Mediterranean. The medicine of Ancient Egypt, reflecting African impulses [**Kush & Meroe**], shaped ideas of civilizations around it, including the medicine of classical Greek and Roman Antiquity. This complex spread abroad, including to African regions, through the influence of Islamic Medicine and Galenic Medicine, [**Arab-Islamic medicine**] which shared common humoral ideas. Another dimension of Islam, namely Medicine of the Prophet, brought other notions of health and healing to Africa from Persian and Arabia. [**Christian healing**] Christian Faith Healing, spread first with ancient Christianity across North Africa and Ethiopia, then later with European influence to Sub-Saharan Africa. **Post-Enlightenment science applied to medicine**, building upon ancient medicine, brought its ideas of public health and curative medicine to Africa.. All these perspectives coexist in the twentieth century with "African perspectives

²⁸ This was the lecture with which I opened my 2004 Vienna undergraduate class. Its text is derived from a series of overviews of African healing and medicine I have written in the past decade, including: “Therapeutic Traditions of Africa: A Historical Perspective” Introduction to Part Three (pp. 163-174) of *The Social Basis of Health and Healing in Africa*, eds. Steven Feierman & John Janzen, Berkeley, University of California Press, 1992; “Healing, an Overview” *Encyclopedia of Africa South of the Sahara*.ed. John Middleton. New York:Charles Scribner’s Sons, 1997, pp. 274-283; “Sub-Saharan African Healing.” Lincolnwood, IL:*Ancient Healing*. Publications International, 1997, Pp. 322-337; "Continuity, Change, and Challenge in African Medicine," In *Medicine across Cultures: The History of Non-Western Medicine*, ed. Helain Selin. Dordrecht: Kluwer Academic Publishers, 2003, pp.1-26, with Edward C. Green.

on health, sickness and healing" which will be sketched in this essay in their own right and in relation to the other traditions as they have evolved historically.

The content of African therapeutic traditions

The prevailing African ideas, practices, and institutions covering health, sickness and healing have over the centuries included (1) empirical therapies based on careful--although not necessarily "experimental"--observation of sickness and the appropriate means of intervention; (2) ritualized therapies that purposefully heighten affect by the therapist within an extensive symbolic framework of singing, dancing, and the metaphoric uses of natural and cultural objects; (3) collective therapeutic rites conducted by associations of those formerly afflicted who have become healers; (4) divination, the systematic scrutiny of misfortune within the rubric of distinctive etiologies and epistemologies; and (5) ideas of adaptive order, that is, general cultural values and concepts that promote health in the lives of ordinary people.

Ancient roots, modern branches

It is likely that some of the features of Sub-Saharan African healing are adaptations of ancient hunting and gathering practices, that have been retained in current local therapeutic practices. For example until recently most healers collected their medicinal plants from the wild [**Nganga Kitembo, Kongo healer with plants**], assembling medicines fresh for each case in the village or city, although, in this author's experience, enterprising healers have incorporated the cultivation of medicinal plants, in a kind of analogy of agriculture, and a more intentionally and controlled human use of natural materials. [**Nzoamambu's garden settlement**] [**Bukavu institute gardens**] Laboratory analysis of medicinal plants in Sub-Saharan Africa needed to await modern scientific and pharmaceutical education, but it has yielded a different, even more intensified use and an analytical understanding of the same materia medica that was once picked from the wild. [**Byamungu's lab, Bukavu**] It is therefore useful to trace the broad history of the domestication of food plants and livestock, and the sedentarization of community life in Sub-Saharan Africa, as a moving threshold that also affected health and healing.

In West Africa, the domestication of plants and animals in sedentary settlements was well underway by 1000 B.C. giving rise to numerous local healing traditions. Urban centers and stratified societies emerged in the savanna by the early centuries of the first millennium A.D.; trade routes linked West Africa with the Mediterranean and Europe. By the early second millennium A.D. the influences of Islam and Arabia were felt in the savanna, without fully supplanting pre-Islamic healing rituals or therapeutic practices.

The spread of food cultivation and sedentary social modes southward through and around the equatorial rainforest has come to be associated with the spread of the Bantu, Cushitic, and Nilotic cultures and languages. Perhaps as early as 1000 B.C. the Bantu languages had begun to spread from the border area of Cameroon and Nigeria. These languages ultimately came to be spoken throughout the whole of central, eastern, and southern Africa. Food production and ironworking spread rapidly through this area during the first millennium A.D., in some cases the one and the same process. In this vast area of Sub-Saharan Africa, many health-related terms and concepts are comparable because of the common linguistic and cultural background.

Ecological settings have shaped ideas and practices in African therapeutics. Both the West African and the Bantu-speaking civilizations, defined primarily by sedentary agriculture, have however been

obliged to articulate with pastoral nomadism throughout their histories. Where the tsetse fly has been absent--as across the Sahel, across the eastern Sudan, in the lake region of East-Central Africa, and into moderate Southern Africa--pastoralism has conveyed a distinctive set of ideas about health sickness and medicine. **[pastoral herd, Sahel, Senegal]** For example, in the Interlacustrine region where the agricultural and pastoral traditions overlap, nearly as many medicinal plants are used for animal husbandry purposes as in human healing. Similarly, other environmental zones of desert, tropical rainforest, and savanna, have exerted their influences on health and healing. In many markets of West and Central Africa, sections are devoted to the medical plants of the rainforest on the one hand, and to the arid regions on the other. **[Kinshasa market]** Over the centuries, both the ecological settings and the cultural traditions have slowly and surely created distinctive emphases within the common core of therapeutic ideas, practices, and institutions which have determined how the therapeutic traditions from the Mediterranean North, the Islamic East, and the Christianized and scientized West would be received.

The common core of ideas of health and ill health

Sub-Saharan African understandings of health, sickness and healing, as in other classical healing traditions, are couched in a basic set of ideas about the nature of the world and life within it, and which readily offer powerful metaphors with which to make sense of inchoate suffering and uncertainty. These ideas are sometimes discernible in verbal concepts that have a deep history and broad geographical and cultural distribution, and a continuing use in diagnosis, the formulation of the sickness experience, and in therapeutic traditions. They include, but are not limited to, the following examples.

The first example of an organizing idea around health, sickness, and healing defines an ideal ordered structure of the body as a whole. **[illness or wound terms: puta, duad, donda]** Any disruption, negation, or distortion of this ideal suggests sickness, defined in terms of the appearance of redness on the otherwise whole skin surface (eela or ele in Yoruba of Nigeria, beela in Kongo of Western Zaire). In Anthony Buckley's *Yoruba Medicine* (1985) this notion brings into play the widespread triadic color code of white chalk as purity and wholeness, red as transition and danger, and charcoal black as human chaos. **[-*pemba- triadic color on body?]**

In a second idea, "balance" or "harmony" is necessary to a state of health in the relationship between an individual and the surrounding persons, as well as between the human community and the natural and spiritual environment (lunga, in Zulu of South Africa, and Kongo of Western Zaire, where this is also an attribute of God). In regions and societies influenced by Galenic humoral theory via Islamic medicine, balance may have the connotation of an equilibrium between the humors, and between heat and cold. Balance between opposing humors or fluids leads to health, imbalance to disease.

A third idea expresses purity, a ritual state in which the dimensions of the human world are in order, right; its opposite, a state in which these affairs are out of order, causing ritual pollution or sickness.²⁹ Edward Green, in connection with the incorporation of healers in health education programs, believes

²⁹ see Mary Douglas, *Purity and Danger* (1966) for this among the Lele of the Kasai in Congo, Harriet Ngubane among the Zulu, Janzen among the Kongo and E. Green in Mozambique.

that purity and pollution concepts represent a traditional set of natural contrasts that are not bound by spirit or human forces, that may have served in the past as a foundation for ideas of health and the prevention of disease.

The fourth concept is the incorporation of the ill, direct confrontation with the malady, e.g., spirit of illness, the sending agent or spirit;

A fifth concept is that of "coolness" as grace, style, and health, in contrast to "heat" of conflict, and ill-health (widely distributed in Sub-Saharan Africa under the term pod [-***pod- distribution, associated with cupping horn**] in connection with cooling down, being cured (Janzen in *Ngoma*, Blakeleys re Hema of Eastern Zaire). The Sub-Saharan African concept of the "cool" extends an aesthetic notion widely seen in the arts and in human relations into a definition of health.

Sixthly, the concept of "flow and blockage" is very widespread, often seen as a homology between the physical realm of the body and exchanges in society, such that both of which are seen as needing to flow openly to live and thrive. [**Nzoamambu's drawing of this in his anatomy**] "Flow and blockage" is a dominant metaphor by which these substances flow within the body social and physical, contributing to health, whereas blockage through envy and ill-will may lead to constipation, infertility, witchcraft, and disease.³⁰

These higher-level ideas often provide the imagery by which sickness is articulated, and the state of health that is impaired. But the question is, how do they inform the very particular treatments that are found to address particular afflictions. This question has not been studied very systematically. However, some indications are available to suggest the relationship between a kind of empiricism or pragmatism and the higher level principles of health and sickness.

For example, what modern medical scientists might understand as "contagion" in the spread of microorganisms of disease, is in fact a relatively old idea even in academic medicine that goes back well before the theory of microbial vectors of disease. It is a widely held notion in African thinking about health, although that which spreads and infects may include ill will, poison, malefic medicines, and a variety of forces which may cause harm. Quite possibly this thinking was applied to specific diseases, in the modern understanding. It is well known that smallpox-infested communities were quarantined as a health measure, and that the healthy were immunized with a bit of fluid from the pustule of an infected individual. Edward Green believes that pollution theory was used to account for certain intestinal ailments in Southeast Africa. "Snake in the stomach" was seen as a kind of intestinal intruder that needed to be evicted by purgatives, or cleansers, to purify the bodily passage. An elaborate notion of color and plant balance was often present in Kongo compounds and medicines, as established in this author's earlier work. Wild and domestic plants, male and female, white and red flowers or fluids, were combined to obtain a satisfactory active ingredient that would balance and purify the individual or body to counteract the diseased condition. It is safe to assume that the principles enumerated here would have been engaged to think about and on which to base many of the practical diagnoses and interventions in the host of cases including bone-setting, midwifery, and a host of specific interventions for such ailments as fever, rheumatism, intestinal disorders, parasites, lactation deficiency, earache, toothache, headache, epilepsy, menstrual disorders, and more. The medications would be based on a

³⁰ For example, Christopher Taylor, *Milk, Honey, and Money: Changing Concepts in Rwandan Healing* (1992).

wide array of mineral, animal, and especially vegetable substances reflecting the desert, savanna and rainforest ecologies.

Equatorial African Medicine: Evidence from Medicinal Plants³¹

In accompanying photos Nganga Kitembo of Balari Commune, North Manianga, emerges from his forest with a handful of medicinal plants;. In another photo, Kitembo instructs chief Kusikila and Dr. Arkininstall on collection of plants for identification. A total of 183 plants were collected for identification by botanists at Lovanium University, Kinshasa. These were published in an appendix in *The Quest for Therapy in Lower Zaire*.

Our project on health and healing was couched in the understanding that plants were an important part of healing, although by no means the only substances used. The project was conceived at a time when agencies were gearing up to research the pharmacopeia of tropical traditions for their potential in the manufacture of medicines for all sorts of diseases. The herbarium was mainly collected under the auspices of Dr. William Arkininstall, M.D., who was supported by my 1968-9 postdoctoral research fellowship from the Social Science Research Council.³² The research proposed to undertake (1) a substantial investigation of the taxonomy of disease ... in Manianga terms; which would involve the (2) compilation of a representative inventory of case histories...and (3) understanding the native system of plant classification, especially medicinal plants; ... so as to (4) act as a liaison between the herbalist and a pharmaceutical firm or plant analyst to ascertain the medicinal value of current plant treatments; finally, ... (5) to determine the social role of the various types of healers—herbalists, prophet-seers, native orthopedists, obstetricians, and other offices overlapping with secular authority, so as to clarify the entire relationship of healing to authority.

The Arkininstall/Janzen herbarium will be presented here under rubrics of the most common disease conditions for which our sources—mainly herbalist-healers, and other lay folk-- agreed to identify plants in terms of their medicinal uses. The following itemization includes the disease condition or category, the local name for the plant, the Latin identification, and particulars about applications.

Lactogenic plants

5. *Munzeke-nzeke*: *Abrus precatorius* L. = Papil. Lactogen taken orally (with ## 6 & 8)

6. *Lubala-mukanga*: *Manotes griffoniana* Baill. =Connar. Lactogen taken orally (with ## 5 & 8)

7. *Kangaya* (male): *Setaria megaphylla* (Steud.) Thy. Dur. Et Schinz. =Graminae. Lactogen, taken orally with # 8)

8. *Kangaya* (female): *Setaria megaphylla* (Steud.) Thy. Dur. Et Schinz. =Graminae. Lactogen, taken orally with ## 5 & 6)

23. *Nkamba*: *Clorophora excelsa* *(Welw.) Benth.=Moraceae. Lactogen.

82. *Nseke-nseke*: *Abrus* cfr. *Precatorius* L.= Papilionaceae. Lactogene & milk purification.

Intestinal distress, worms

³¹ This section is based on part of a presentation for the panel “Collecting the Congo: Acquisition, Categorization and Contested Possession of Congolese Material Culture,” organized by Sarah Van Beurden for the African Studies Association Meetings, New Orleans, November 19-22, 2009.

³² See Appendix, *Quest for Therapy in Lower Zaire* (1978) for the herbarium and its Latin identification by Professor Evrard of Lovanium University;

11. *Nlulu*: *Annona arenaria* Thonn. =Annonaceae. Abdominal pain & skin sores;
 12. *Kinsangula*: *Maprounea africana* Mull. Arg.=Euphorb. Roots for stomach pain, worms;
 13. *Mumpala-mbaki*: *Crossopteryx febrifuga* (Afz. Ex. G. Don) Benth. Infantile diarrhea;
 18. *Nsumbi-nsumbi*: *Combretum*=Combretaceae. Bloody diarrhea, limb swelling;
 21. *Fula*: *Cassia occidentalis* L. =Caesalpiniaceae, stomach pain, worms;
 30. *Tumvumvu*: *Sida acuta* Burm. F.=Malvaceae, liquid from leaves, for diarrhea;
 36. *Lubota*: *Millettia versicolor* Welw. Ex Bak.=Papilionaceae, diarrhea, headache, worms;
 43. *Patakani*: Cfr. *Lactuca* sp.=Compositae, drink from leaves for diarrhea;
 46. *Mufilu*: *Vitex* cfr. *Madiensis* Oliv.=Verbenaceae, diarrhea, cough;
 49. *Munungu-musitu*, *Rauwolfia mannii* Stapf.=Apocynaceae, roots in liquid for stomachache;
 53. *Lunama*: *Desmodium velutinum* (Willd) DC.=Papilionaceae, diarrhea;
 64. *Muntense-mankelele*: *Maesopsis Eminii* Engl.=Rhamnaceae, bark in palmwine for worms;
 83. *Mfilu*: ????, roots in water, drunk for bloody diarrhea;
 91. *Dinsongi*: *Leonotis nepetifolia* (L.) Ait.=Labiatae, fruits in liquid for stomachache;
 96. *Tumvumvu*: *Sida acuta* Burm. F.=Malvaceae, diarrhea;
 109. *Masisia-sisia*: *Aframomum* sp.=Zingiberaceae, roots for enema to treat stomachache;
 119: *Lolo Ntumbi*: *Nauclea* cfr. *Gilletii* (De Wild.) Merr.=Rubiaceae, stomachache.
 122. *Kilemba-nzau*: *Solanum* sp. =Solanaceae. Leaves for purgatives
 123. *Dia ba mvudi* (*Ba dia mvudi?*): *Eupatorium africanum* Oliv. Et Hiern. =Compositae. Leaves to treat diarrhea;
 130. *Nkuki*: Cfr. *Symphonia globulifera* L. f.=Guttif. Bark to treat stomach swelling;
 131. *Vamu*: ? Euphorbiaceae. Bark for child's purge;
 133. *Mpunga*: *Trimfetta cordiafolia* A. Rich. =Tiliaceae. Juice of bark in eyes for diarrhea;
 134. *Bumi* (female): *Cassia alata* L. =Caesalpiniaceae. Roots, to treat stomach;
 138. *Luvangu*: *Dichrostachys cinerea* (L.) Wright et Arn. = Mimosaceae. Roots boiled to treat stomach & vomiting;
 144. *Ntuti-tufi*: ? Ranunculaceae? Bark for intestinal worms;
 155. *Bole*: *Dalbergia gentilii* De Wild. = Papilionaceae. Bark, in enema for worms;
 157. *Mvete*: *Hymenocardia acida* Tul. =Euphorbiaceae. Boiled roots w. lemonade for dysentery;

Lubanzi, “stitch-in-side”

15. *Nkunga-mbwa*. *Pteridium aquilinum* (L.) Kuhn.=Pterid. Lubanzi, hemorrhoids.
 41. *Munkula-mvumbi*. *Steganotaenia araliacea* Hochst. =Ombelliferae. Prepare drink from leaves for lubanzi.
 85. *Nkila-mbwa*. *Pennisetum polystachyon* (L.) Schultes.=Gramineae. Rubbed on rib cage for lubanzi.
 126. *Mfilu*. *Vitex* sp.=Verbenaceae, fruits in treatment of lubanzi (with # 132)
 132. *Nsolo-nsonso*. *Rottboellia exaltata* L. f.=Gramineae. Crushed with fruit of mfilu (# 126), to treat lubanzi;
 149. *Nsolokoto*. *Bidens pilosa* L. =Compositae, lubanzi.

Heart pain, palpitations

33. *Mumpoko*. ??? Heart pain, incoherent speech;
 45. *Muzeke-zeke*. *Tristemma* sp. =Melastomataceae. Rubbed into skin incisions for heart palpitations (with 47 & 54);
 47. *Lubata-bata*. *Costus spectabilis* (Fenzi.) K. Schum. + zingiberaceae. Rubbed into skin incisions for heart palpitations (with 45 & 54)

54. *Mulondo*. *Schwenckia americana* Linn. =Solanaceae. Rubbed into skin incisions for heart palpitations (with 45 & 47);
 67. *Fuma-dia-nseke*. *Erigeron floribundus* (H.B. et K.) Sch. Bip. =Compositae. Headache, heartache;
 94. *Nlulukulu*. *Vernonia colorata* (Willd.) Drake. =Compositae. With other plants for heart pain;
 97. *Nungu* (pepper). *Capsicum frutescens* L. =Solanaceae. Juice of leaves in eyes for headache or heartache, also put in food;

Madness, anti-social behavior, loss of speech

25. *Fumu-dia-nseke*. *Erigeron floribundus* (H.B. et K.) Sch. Bip.
 39. *Mpoko*. ??? Calm antisocial behavior;
 160. *Mumpoko*. *Asystasia gangetica* (L.) T. Anders. = Acanthaceae.
 40. *Mufuma*. *Ceiba pentandra* (L.) Gaertn. = Bombacaceae. Madness.
 51. *Mpamba-munti*. *Culcasia* cfr. *Sascatilis* A. Chev. = Araceae. To calm hysterical loss of speech;
 55. *Mesa-nkama*. ??? Bark boiled in water & drunk to treat madness, loss of speech;
 56. *Lemba-lemba*. *Brillantaisia patula*. T. Anders. = Acanthaceae;
 66. *Meso-nkama*. ??? Bark, for speechlessness;
 74. *Kilembe-lembe kia ndombe*. *Virectaria Multiflora* (Sm.) Bremek.-Rubiaceae. To prepare liquid to calm madness (with ## 75, 56, 25)
 75. *Lemba-ntoko*. *Piper Um bellatum* L. = Piperaceae.
 112, 113. *Dinkondo dia kimbiti*. *Anchomanes difformis* (BL.) Engl. =Araceae. Roots used to treat madness;

In our conversations with herbalists and other healers we stressed the goal of research and understanding so as to promote their medicine following the repression of the colonial era. We did not offer financial remuneration, on the grounds that we were fairly sure that unscrupulous folks would sell us anything and call it important herbal medicine. We assured the healer-herbalists and others that we had made arrangements to deposit one set of plants for identification with the national botanical department in Lovanium University. We were assisted in our herbarium assemblage by an important figure, Kivunda communal mayor Kusikila Joswe. He was very interested in the project and often accompanied us on our trips. We told healer-herbalists that we would credit them with the knowledge that they shared with us. It is perhaps surprising that some did in fact contribute to the herbarium.

We did not use signed consent forms, since this convention that has since become standard in institutional research clearance did not yet exist. But we did invite healer-herbalists to share their work and material with us. We depended entirely on their good will and willing participation. Fully two-thirds of the healer-herbalists with whom we met shared some of their plants with us and allowed us to witness their healing sessions.

Still, the other third were reluctant to work with us. For some it was a case of having had bad experiences in the colonial era, gotten into trouble with authorities. They did not know us well, and had no independent references about us. Others seriously questioned whether they would “lose” their knowledge if they gave it up to us. One healer some of whose plant insights had come from ancestral visions was reluctant to divulge his spiritual insights. This seemed to be a private thing with him. Another was a shrewd entrepreneur who sensed in us a competitor. How was it resolved? We simply accepted the wall of rejection in these instances. Sometimes we offered to return, but in the end some simply refused to cooperate with us.

The refusniks' judgment has perhaps been vindicated in ensuing years. Many bioprospecting initiatives have not resulted in the remuneration of healer-herbalists knowledge and access to resources. They have been exploited by pharmaceutical companies and even national research centers, as well as by international scholars. One Lower Congo pharmacist who developed a company after our research travelled to Kansas to bring plant samples to the medicinal chemistry lab at the University. This unfortunately ran aground on the shoals of Congolese political chaos. However, today many countries abide by international conventions that protect the natural resources such as important medicinal plants.

Equatorial African Medicine: The Structure of a Particular Tradition ³³

In Kongo society, which may more broadly stand for Western Equatorial African societies, concepts, verbal categories, and health and healing processes in one way and another reflect the foregoing general ideas of health, sickness and healing. It is important to show the particulars of a single region or healing tradition so that it is possible to grasp how the higher level, abstract, ideas actually are embedded in particular sickness modes, therapies, and ideals of wellbeing.

The Kongo distinguish between afflictions and conditions of natural origin, 'caused by God' (*kia Nzambi*). and those of human complexion, (*kia muntu*). **[chart with this dichotomy as a continuum]** Although this distinction is frequently heard as such in diagnostic discussions among kinsmen, and in the seances of prophet-diviners, a host of euphemisms articulate a wide range of etiologies between these two possibilities: personal disregard for health and diet; disregard for social etiquette and society's rules; spirit-related causes such as the wrath of ancestors, or water spirits, or the spirits of twins. An aura of pollutedness usually accompanies sickness attributed to "human cause", requiring the sufferer and his kin to seek purification through sacrifices, confessions and gift exchanges to achieve reintegration to, or equilibrium in, the community of lineage, village, or town. Much human-caused affliction in current Kongo thinking is attributed to situations of contradiction in which persons are at odds or cross-purposes with one another (consciously or unconsciously) as in land disputes, or in the competition for resources over profit-making enterprises, on the one hand, or for lineage ceremonial and welfare funds on the other. Staff conflicts in modern bureaucracies and job settings also occasion the diagnosis of "human' cause. All these situations are believed to arouse ill will and envy in people, and to lead directly to break- down of health in the antagonists, or to their death. The grammar of human-caused affliction is articulated in terms of witchcraft (*kindoki*) and, nefarious magic (*min'kisi*. or *magie*), Witchcraft is concentrated in the power of words such as gossip, oaths and curses (*lok*. or *loka*). as well as hereditary possession of witchcraft power glands [*kundu*)]— which may also be at the basis of a chief's or politician's power. Magic or *n'kisi* (also spoken of as 'fetichisme' by some) as an etiology of affliction arises from the tumultuous history of Kongo ritual in Western biomedicine has largely been integrated into the level of *bilongo* medicines, although some procedures have the character of *min'kisi* which recurrent reform movements have discarded part or all of a region's consecrated medicinal (*min'kisi*) paraphernalia, in the hope of making a new beginning, only to have individuals here and there begin anew to enshrine their visions as modern-day medicines. **[Loka, dok, distribution]** Thus, most people, especially those who have no medicines of their own, consider others' use of magical medicines as defensive mechanisms a potential cause of sickness. The idea of an *n'kisi*-caused affliction merges, however, into the area of nature spirits and the way they present certain power, albinos, sacred children, and auspicious places and persons. In the era of modern

³³ This section is from an article "The Need for a Taxonomy of Health in the Study of African Therapies" originally given in a conference at Cambridge University on classification and causality in African medical thought, and published in *Social Science & Medicine* Vol 25B (1981), pp. 285-294.

Kongo prophets, school education, and Christianity, many BaKongo do not have direct access to the legitimate tradition of consecrated medicines: but the tradition is still there, beneath the surface, maintained by priest-doctors somewhat surreptitiously.

This range of causal agents and forces thus spans the continuum from human cause to natural (God) cause, with a great deal of diagnostic shifting if circumstances warrant it. The shifting from one domain to another is not arbitrary, as Horton suggests, but is based on evidence in a case. To be sure, the distinction between *bisimbi* water spirits and ancestor spirits, or between spirits and human witchcraft, may seem like hair-splitting, even to BaKongo, but in the context of specific cases these differences often spell the difference between accusing parties present directly to their faces, and modulating the causal imputation somewhat so as to enhance harmony between persons present. The concept of nature, contained in the 'God-caused' or 'God-related' (*kia Nzambi*) condition, has very little to do with divine retribution. It is more a view of something in the nature of things, likely a gully 'of God' that has washed in a field by a rainstorm. It is likely that this view of nature is closer to the European idea of natural law than often thought, for there are, in Kongo culture, well-developed ideas about cyclic accumulation of life and permanent properties in natural substances which have predictable results if used in certain ways.

The taxonomic system spelled out here is extremely stable, having resisted centuries of change and major efforts by colonial and missionary educators to alter the Kongo view of the world. The categories may well be as fixed as Horton suggests, although they are open, subject to successive changes of particular contents. This is apparent in the system of medicines and treatments used to respond to ills arising from these causal forces, and it is apparent in the way Kongo health continues to be defined. Flowing from these assumptions about the nature of the world and the causes of fortune and misfortune, Kongo therapeutics and its appropriate specialists are articulated. A hierarchy of medicines, from simple and relatively weak, to composite and powerful, from curative to health-supporting, may be seen. Simple plants are called *minti*, (trees, bushes, or *makaya*, leaves). A more general term for medicine is *bilongo*, which includes plant compacts, bottles of ointment, pills, injections and other hospital medicines. *Bilongo* may be simple or composite, they may be administered by a layman or a specialist. By definition, this level of medicine is different from consecrated medicines (*min'kisi*) which must be handled only by consecrated specialists (banganga).

Western biomedicine has largely been integrated into this level of simple *bilongo* medicines, for the treatment of diseases understood as 'natural'. Diviners, various prophets, and lay therapy managers have been quick to discern the areas of competence of biomedicine, and the nature of its classificatory focus. They are impressed with the direct cures of biomedicine for smallpox, bilharzia, sleeping sickness parasites, malaria, and others which their traditional pharmacopeia handled less well. Thus, in many areas, traditional medicines are replaced by manufactured synthetic drugs when available and affordable. But Kongo diagnosticians have been as quick to see the outer parameters of biomedicine, in terms of their classifications. First Western practitioners denied the reality of human-caused afflictions, of witchcraft and *min'kisi* caused illness. Then, too, the therapies of biomedicine didn't address issues of pollution, vulnerability, and anger. The consequence was that BaKongo worked out a rather intricate selection rationale for utilizing the treatment appropriate for the particular cause perceived. It is true that a host of diseases such as fevers, infections, and pathologies once dealt with in terms of human causation have now, with greater scientific knowledge in the Kongo

community, come to be dealt with as natural causation. But new issues and problems have arisen in modern life which require continuing treatment in those terms.

Minkisi, consecrated medicines proper, have a charter going back to a vision, fixed recipes of ingredients (*bilongo*), techniques, and spells or songs and dances, and they require specialists. For they are 'too hot' for laymen to handle. *Min'kisi*, historically, have made their appearance in areas of life where there is crisis, transition, danger, recurrent accident, high responsibility, or core social values. We must not impose too narrow a definition, from narrow physical biomedicine, upon Kongo *min'kisi*. They may be chemotherapeutic compounds of several plants, like the sedative recorded in *The Quest for Therapy*, in the case "A history of madness" for psychotic agitation. They may be manipulative techniques like the cupping horn, used as a symbolic specific to remove pollution from the body of a mixed up sufferer. They may also be massive ritual organizations to control international trade so that local communities are not destroyed through involvement in it. The definitive story of Kongo consecrated medicines has yet to be written, but the more I study particular clusters of medicines carefully, the more respect I gain for them.³⁴

Of course the specialists (*banganga*) who 'compose' (*handa*) these medicines vary in their titles, competences, and importance depending on the medicine. Diviners such as the *ngombo* user, have a history of prominence in Kongo, until replaced by prophet-seers. Other specialists like the cupping-horn users seem to be relatively permanent in their work. Then there are generalists like the *nganga nkisi* who is supposed to know "all" medicines, and the *nganga lunga*, (all-encompassing. *nlunga*) although the one I knew was an orthopedist. There are as many different kinds of specialists as there are medicines, and with 450 years of recorded history to work with, the inventory of both is stunningly rich.

A small cross-section of consecrated medicines stands out in this history of Kongo medicine as being 'drums' (*ngoma. nkonko. n'konzi*), which, according to Kongo attribution, have several functions – whereas the standard *min'kisi* have only one each and are made up of a corporate group membership which participates in periodic ceremonies. It is at the point of moving from simple secular medicines, to consecrated medicines, and especially to corporate drums, that the Kongo medical tradition generates a health institution. Membership consists of fellow sufferers of a common affliction, who, in drawing together, produce a bond, a social contract. Those afflicted or recruited and cured or stabilized in their relationship to the sickness—be it reproductive disorders, hernias, alienation, twins, entrepreneurial zeal-- are considered best suited to become specialized doctors of the ailment for which the drum is known. Sickness is often seen as a sacred calling, manifested as possession by a spirit of a former drummer. If the possessing sickness is placated, the disease brought under control, it at once purifies and energizes the individual, placing him in debt to society which henceforth expects him to consecrate his newly found gifts as medium in this specialized domain to the service of others. The ingenuous quality of the historic, fully-incorporated, drum is that it presents a relatively specific health view to a given clientele with the means of sustaining it through particular behaviors and supportive others.

³⁴ J.M.Janzen, *Quest for Therapy*, 1978, pp. 37-66; J.M.Janzen, "Ideologies and institutions in the precolonial history of Equatorial African therapeutic systems," *Social Science & Medicine*, 13B (1979), pp. 317-326; J.M.Janzen, *Lemba*, 1982, p. 26.

Here too. as in the matter-of-fact medicine addressed to the naturally-caused afflictions, there are changes. Drums tend to flourish in relatively stable times where centralized power is not too strong. This explains, I suspect, their absence in Zulu society, or in colonial society. They have thrived on the edges of empires, as among the Ndembu where Turner gives good account of them, and between states, as in the caravan regions between Malebo Pool of Lower Zaire and the coastal trading posts. In times of rapid change well-defined drums may dissolve, to be replaced by ephemeral movements symptomatic of the troubling issues facing the society. They wax and wane, offering the scholar a clear indicator of socio-cultural stability and of the strains of sociocultural change. In Kongo society independent churches, mission churches, civic associations, and neo-cultic organizations such as the Rosicrucians have stepped in to fill the gap left by the disintegration of some of the well-known pre-twentieth century drums like Lemba.

Of course, urban industrial life has presented BaKongo with new kinds of issues: the tensions of wage labor, job competition, political responsibility and uncertainly, alienation, and the like. Some new drums have emerged, in the old genre, as well. as the case of Zebola. reported by Corin.³⁵ But the genre of the drum (*ngoma*), which spans the mid-continent from Matadi to Dar es Salaam is a vehicle of African therapeutics to provide a means of surmounting curative measures against disease and achieving the construction of a partial 'utopia of health'.

In the past. conscious structures of health and adaptation have been worked out in the context of drums and related political structures of the community, and in general attitudes of social harmony. It remains to be seen to what extent the real problems of industrial society can be inserted into this format, although some good examples may be named, like the Zebola. or the Beni-Ngoma (Kalela Dance) of the Copper Belt. There is always the danger, as expressed by Swantz in her work on Tanzania, that the symbols of a therapeutic community fragment into magical tools for use in individual power plays. Expressed in competing jinn spirits, or as in Kongo society, witchcraft accusation and the suspicion of run-away magical aggression.

But then medicines have always in fact fallen short of the expected, or promised, aim. This fact does not daunt the human spirit, apparently, nor should it discourage the analyst from trying to grasp the utopia of health which generates the patterns of classification and causation. For the Kongo, this has been expertly formulated by Mahaniah:
 [When sickness occurs], "all community members are mobilized and concerned. A rapid and effective solution must be found to re-establish the normal equilibrium of the subject. This essentially ritual treatment aims to purify the community and with the return of harmony, to guarantee general well-being. These practices, at once religious and medical, are seen as an intervention of supernatural forces which have as their function to re-establish an harmonious order. Thus, to treat a sufferer is not only to re-establish his organic-physical normality, but also to recreate the order characterized by social and ritual harmony. A harmonious society...is one in which there are no social conflicts, no sicknesses, no disasters, epidemics or premature deaths. ...where people do not practice cursing, sorcery and fetishism and where there are good relations between the living and the ancestral world. This new order, is the result of a ritual purification of the community and the eradication of spells and nefarious fetishes, the sign of the golden age each one awaits."

³⁵ Ellen Corin, "A possession therapy in an urban setting: Zebola in Kinshasa" *Soc. Sci. Med.* 13B (1979), 327.

The shift from mundane to ritualized therapies

As important as the practical medicines are the ritualized therapies, or, the ritualization of therapy, defined as the purposeful amplification of mundane or empirical therapies with highly charged affective symbols. Where and when these therapies are invoked depends on the understanding of the cause of the misfortune, and what may be seen as an appropriate handling of it.

The shift from mundane to ritualized therapy, to deal with the shift from "low density" to "high density" cases, occurs because the misfortune or affliction is perceived to be fraught with tension, anxiety, and fear of pollution by both human and superhuman conflict. The stakes are higher, thus the symbolic realms of human relations need to be reordered and regulated. Only consecrated persons are capable of handling such powerful therapies as the purification of polluted persons and settings, making sacrifices to ancestors or neutralizing menacing spirits. The social dimension of misfortune is highly appreciated in the African setting. Analysis of this dimension is often the first item of the therapy management group's agenda, or of the diviner's to whom they may pass a case.

Divination

The pervasiveness of divination in relation to African sickness and misfortune attests to the importance of the general questions about causation, especially the suspected shift in cause from a mundane to a highly charged cause in the human or spirit realm. Over a wide region of Africa, etiological imputation of misfortune allows for that which "just happens", an etiology which has been translated by some as "natural cause". Many African glosses of this etiology are translated as misfortune caused "by God", not of divine retribution of Islam or Christianity, but as made in the order of creation. The diviner may thus tell the client that his or her case does not entail anything to worry about, that it is "of God", that is in the nature of creation. This is helpful to the client, for it lifts the case and its diagnosis to a more general level of thought and representation that ties together the many approaches available to African therapeutics.

Usually consultation with a diviner is not undertaken until there is sufficient reason in the kin group of the sufferer to suspect causes other than the natural. Such a precipitating factor may be the worsening turn of a sick person, a sudden and inexplicable death, or, the juxtaposition of a sickness with a conflict in the close social proximity to the sufferer, or the puzzling incidence of a disease which strikes one side of a family and not another. In such cases the clients are looking for an answer to their question not only of "why did it happen?" but "why did it happen to us?" and "who caused it?" as well as "what should we do about it?" Most often these questions will be answered by pointing to the human causes of a misfortune, including error in judgment by the sufferer, excesses of various kinds, inconsistencies, contradictions, rivalries and conflicts in the immediate social field around the sufferer, as well as willful gossip, the power of harmful words, poisonings, and attempted mystical killings.

The advancement of health and scientific understanding in a community may not necessarily lay to rest these questions, which are of a different order from the ideas in natural causation. A community of individuals may know very well that the malaria spirochete transmitted by the bite of an anopheles mosquito causes malaria in the blood of a human. But the diviner may shed light on the question of why some people in a kin group are infected and not others, or why some died and not others when all

were infected. Divination may also clarify the human causes behind accidents, or provide a pattern with which to explain it.

As pervasive as divination is across the African continent, its particular instrumentalities vary enormously, as illustrated by a few widespread examples. In the broad West Africa belt from Central Nigeria to Ghana, the prevailing mode of divination is known as Ifa, or one of its variants. Using a cup or tray, a set of cowries or pods is thrown out whose combination of "ups" and "downs" is coded to indicate a set of verses, numbering in the hundreds and thousands, which illuminate the life situation involved in the affair before the diviner. On the Southern Savanna, from the Kongo coast southeastward to the Copper Belt, the Ngombo basket mode of divination is common. [**ngombo, one of many types**] Carved figurines and natural objects, representing human situations and predicaments, lie together in the basket. As the basket is shaken, one of the objects emerges to the fore at the basket's rim between two lumps of clay, one red, the other white, suggesting the liminality of the threshold between the visible and the invisible, spirit world. The diviner then "reads" the case before him in the light of the emergent object or the constellation in the basket.

These widespread, and many other types of divination in Sub-Saharan Africa, are predicated on the assumption that sickness or other misfortunes may be caused by an untoward turn of events in the human or related spirit world. Immediate proximal cause may act within the prism of human or spirit agents. Thus, despite widespread acceptance of modern science in Africa, divination continues to be widespread as a means of unscrambling the human factor that is seen as important in the cause of misfortune.

Rules, words, and will in the cause of sickness and misfortune

The texture of human society is extremely rich and nuanced in Sub-Saharan. This writing can only mention a few examples of the role of agency in believed cause of misfortune. [***-gidu-**] A widespread verbal concept whose radical is abstracted as ***-gidu-** refers to the role of social prohibitions, taboos, and the consequences of their violation. Sometimes this is mentioned with reference to the restriction on eating or killing one's clan or individual totems and familiars. Other observers, especially well-versed African physicians, note that these prohibitions help individuals adhere to social codes in general, including health promoting restrictions on such things as over-consumption of alcohol, over-eating, or health destroying excesses of any kind.

Another widespread notion of the human cause of sickness or misfortune encompasses both the anger or ill will toward another, with the instrument expressing it, be that an injurious word, a blow to the head, or a bit of poison in the drink or food. This notion is in fact so ancient in Africa that its radical (reconstructed as ***-dog** or ***-dok**, included in Proto-Bantu lexica of at least 3,000 years ago.) Because of its centrality to the African worldview, modern derivations of it are found from Cameroon and the Kongo coast in the west, to the Swahili coast in the east, to the Nguni-speakers in South Africa, and everywhere in between (*kuloka*, in KiKongo; *kuroga* in Kinyarwanda; *kuthaka* in Zulu). The notion is not always associated with ill will, sometimes it is used simply to refer to the power of words, or the use of powerful words as in oaths or spells, which may well be its original and central semantic core. In contemporary diagnosis of misfortune, victims will often identify a string of misfortunes and try to recall the exact words spoken by others prior to or in association with the events, drawing the logical inference that these utterances had caused, or could have led to, the misfortunes. Particularly words of

warning or injurious words spoken in anger are especially suspect. Therefore, in divination, these moments are recalled so that the individuals or the relationships may be dealt with.

Sickness experience and interpretation of misfortune

Rwandan scholar Pierre-Claver Rwangabo presents Rwandan medicine as if it is a part of the modern reality, rather than a fossilized system at odds with "modern" medicine, although not all aspects of Rwandan medicine are amenable to modern science. Thus, not surprisingly, for him the causal domains of Rwandan medicine are divided at a general level between the "physical and mystical causes". Diseases range across a variety of types which may be attributed to either causal category. Rwangabo's medical training is evident in his listing of disease classes that include: parasitic diseases, microbial diseases, systemic diseases and bodily accidents, gynecological and obstetrical diseases, and psychomental and behavioral diseases. Under the latter group he identifies current psychopathologies that entail abnormal behavior as understood even in traditional thought, and diseases believed to be caused by broken prohibitions and beliefs about ancestors (*abazimu*) and other spirits (*ibitega*, *amahembe*, *nyabingi*, *amashitani*, *amajini*) which often are identified in relation to mental illnesses. He places the diseases resulting from "poisoning" into another category altogether, to which we turn below. Also, misfortunes brought on by the breach of social rules are qualitatively different from the above, and have a "mystical" though not mysterious etiology. Rwangabo notes, correctly, that most pathologies may have a physical dimension and a "mystical" or non-physical dimension, and that this affects, in African thinking, the way its therapy will be arranged. The decision to seek physical or other therapy has to do with the context in which it occurs, its severity and response to treatment.

The treatment for injurious powerful words and other poisons

If sickness and other misfortunes may be caused by the utterance of hurtful words or condemning words, as well as other acts of aggression, then the injuries between humans may be healed through the purging of bodies of their poisons, the intervention of blessed powerful words including songs and gestures, and the administration of strong medicines. This is the logic behind the myriad of ritual therapies across Sub-Saharan Africa.

In West Africa, shrine communities and cult memberships characterize this aspect of healing. Sometimes they are gender-divided, as in the widespread Sande (female) and Poro (male) associations of the Guinea forest region. Elsewhere they take on a more focused, specialized quality, centering around such issues as twinship (as in the Ibeji of Yorubaland), particular forms of disease (Ipona, the cult of smallpox), institutions of central authority or individual achievement (the cult of the hand in Iboland).

Across Equatorial Africa from West to East this type of therapeutic ritual assembly often centers around particular issues as well, such as, again, fertility, twinship, women's reproductive issues, the health and well-being of infants and children, debilitating chronic conditions, fortune and misfortune for men in hunting, mental illnesses, and a range of social and even environmental issues such as poisonous snakes. Membership is usually made up of the afflicted and formerly afflicted, who undergo a therapeutic initiation with stages from sufferer-novice to healer-priest. These "drums of affliction" as Victor Turner dubbed them in a book by that title, are often associated with the drum type *ngoma*

which is pervasive across the region and connotes the voice of the ancestors and spirits which indwell the celebrants, and are expressed in the song-dances at the core of the ritual performances. Often the mark of growth or healing in the sufferer-novice is the articulation of a personal song based on the ordeal of suffering, a dream-vision, or other moving experience. Such a song constitutes a unique set of "powerful words", recalling the cognate *dok*, that offset and overcome the destructive forces of disintegration, misfortune, sickness and chaos of the previous period of the individual's life. Where such an *ngoma* or "drum of affliction" addresses community issues, the healing ritual may be directed to the community, and society becomes the body that is cured. Leaders or segments of society such as households may be the "sufferers" and the "medicines" may be symbols of authority, titles of leadership. This is the case with the 17th to 19th century coastal Equatorial African cult Lemba which arose in response to the chaotic forces of the Atlantic trade within lineage-based society. The sufferers were elite households who feared the envy of their subordinates; their "therapy" included ritual purification, and the massive redistribution of ceremonial wealth obtained in the trade. The result of this therapy was the reconciliation of the redistributive economy of lineages with the class-exacerbating economy of mercantilism. In Nkita, another example of the *ngoma* type therapeutic ritual in Western Equatorial Africa that has reached Haiti in the New World, the gynecological aspects of reproduction within the clan are emphasized, along with the reconciliation of the community of the living with the ancestors. One of the dominant healing metaphors of Nkita is "reweaving the threads of life."

Especially in the twentieth century, the ritual therapeutic attributes of these African cults and shrines have related dynamically to Christianity and Islam. Sometimes the African institution has absorbed the outside idea or symbol, or Christian and Islamic institutions have recreated the African forms and substance. Especially widespread in Sub-Saharan Africa are the Independent African Churches, many of which encourage healing, exorcisms, and various kinds of incorporation of rites of purification, protection, and sanctification. Prophet-founders play the role of ancestor-mediators, while prominent or especially talented members assume the diagnostic role of diviners. These roles are not unknown in the mainstream Mission churches as well where, for nearly half a century, theologians have researched ways to Africanize the form and substance of Christian institutions.

Islam has similarly penetrated African therapeutic culture, and vice-versa. Although orthodox Muslims, just as some Christians, frown on syncretistic blending of African and Near Eastern religion, the interpenetration of Islam and African ritual healing is marked. *Jin* and *amasheitani* spirits widely cohabit the spirit worldviews of *ngoma* associations in Eastern and Central Africa. Muslims healers of the Swahili coast regularly practice *ngoma* as part of their medicine kit, along with reading the Koran; purification symbolism of African healing merges with that of the ritual ablutions of Islam in connection with prayer. In northern Swahili towns such as Lamu, early twentieth century *ngoma* Maulidi was introduced for performance in the mosque; its songs celebrated the prophet Mohammed. Today reform Muslims are trying to extricate it from this setting.

Studies of medicine and healing in the Hausa region of Northern Nigeria by Lewis Wall and Ishmael Abdullah have shown the active incorporation of the teachings of Islam as "virtue and expression of the moral order".

Public health and the relegitimation of African medicine

African forms of perceiving health, sickness, and healing as described here came under severe assault by most colonial regimes and the missionaries who came to evangelize Africa from the late nineteenth to the mid-twentieth century. Just as Islamic crusaders had attacked "pagan" African forms of healing and religion, so Western Christian missions discredited the basis of knowledge as well as the overall approach to ritual healing. Assumptions that human relations could cause sickness were dismissed as superstition or "witchcraft" at a time when the first steps of positive science were discovering the causes of contagious diseases, and the first public health campaigns were being waged to make Africa safe and health for "progress". With their dramatic cures for such diseases as yaws, leprosy, and later malaria and dysentery, Christian missions and their hospitals contributed to the conversions of many Africans. Although Christianity gained widespread following in Sub-Saharan Africa, many of the marks of the African worldview of misfortune have been reincorporated, or followed quietly in private.

Other aspects of the African regard toward health and sickness have been given new legitimation through research. Especially the realm of medicinal plant research has found recognition as African scientists and other scholars search for ways to modernize uniquely African solutions to their needs. Many associations of healers have been formed to bring African healing practices into closer proximity with the legitimation of the nation-state. The financial crises of African societies, and the search for an infrastructure of health, has led planners to take a second look at the African institutions such as the cults of affliction, and the education of healers.

Healing in the aftermath of war

A noteworthy recent feature of African healing has been its widespread role in "healing the wounds of war". Warfare, perhaps the ultimate form of the "malicious power of words and deeds," requires a solution that must achieve the purification of individuals and communities, and the restoration of harmonious ties with the ancestors. Pierre-Claver Rwangabo, in a work published on the eve of the Rwandan holocaust, and two years before he too would be claimed by assassins' bullets, discussed at some length precisely those dimensions with which the post-war healing has to do: overcoming "poisoning" (uburozi, from dok) and dealing with the ancestors (abazimu, a general Sub-Saharan term). He notes that the use of chemical poisons had been a very serious problem in Rwandan society, between siblings in the family, within the lineage, and between rivals in the office and institution, even between spouses. Poisoning was however nothing more than an extension of the power of words, harmful words in particular. It is perhaps not surprising that in a society where poisoning was so common, heightened political tension could escalate to genocide.

In the post-war period, attention has been given to remembering the dead, especially those killed in the war. The ancestors are accorded power to both inflict disease and to overcome, indeed prevent, disease and misfortune. The ancestors are considered to safe-guard the health of their descendants, and to sanction those who forget to remember them. In the well-known African view of ancestors, there are those who are beneficent and those who are prone to be malevolent. Ancestors are considered to be the mediators to Imaana, God, and it is to them that prayers were given. In Rwanda, the cults of heros Ryangomba and Nyabingi, and in Burundi that of Kiranga, celebrated the life of the community and the power of Imaana. Kubandwa is the name of the common cult of Imaana through these mediators.

Other wars approaching the Rwandan war in horror have been studied in the longer-term. Years and decades, rather than months, are required to see the progress from mass dislocation and deep shock to emotional acknowledgement of the events, grieving, and the eventual reconstruction of a memory, including the recognition of the morally-restorative ancestors. Richard Werbner's *Tears of the Dead* (1991) on the aftermath of war in Zimbabwe shows that part of the response to war was to re-establish memory of the prewar ancestors--the *mizimu*--and to bring them back into closer range, while at the same time laying to rest the memory of those who died a violent death and not properly buried--the *ngozi*.

In the Kalanga lineage of Southern Zimbabwe that Werbner had known from before the war, and revisited in the late 1980s, these ancestors were re-connected to the community of the living within the Ndebele-inspired Ngoma rituals. In this revival of Ngoma, the dead were sorted out into good and useful mediums versus threatening or harmful mediums, that is those who had died a violent death or had not been properly buried, or those who had killed others wantonly. This ten-year sorting out of spirits following a war recalls the spirit categories in Swaziland where ngoma spirits are differentiated into those who are "victims of Swazi wars," "died by drowning, and received no proper burial", nature spirits, and the lineal ancestors. The "victims of Swazi wars" category recalls the early 19th century wars of Southern Africa, but the whole constellation of memories, stories, divination and healing rituals offer a paradigm for dealing with lesser traumas of today.

The focused ritual of reconnecting to the pre-war ancestors, and marginalizing the "ngozi", thereby creating a nuanced worldview of healing, exorcism, and mediumship, is a powerful trauma treatment procedure. The ancestors are an extension of living humans who have suffered all the horrors of war, indeed, these ancestors are the icons of those terrible moments, some having been killed, others having done the killing. The open wounds of war in Rwanda are the fear, shock, denial, and blaming of others--all the emotions Western therapists associate with long-term psychological damage that takes years if not lifetimes to heal. The collective trauma is so great and this healing process so momentous that the spirit paradigms that result may continue, as in Swaziland, for decades or even centuries.

Health, sickness and healing is thus a rich and highly developed dimension of Sub-Saharan African civilization that has grown both as it meets the needs of its peoples, and as it incorporates ideas and techniques from the outside.

Chapter 4

DAYBREAK IN THE HEART OF DARKNESS: PUBLIC HEALTH IN EARLY COLONIAL LOWER CONGO

Introduction ³⁶

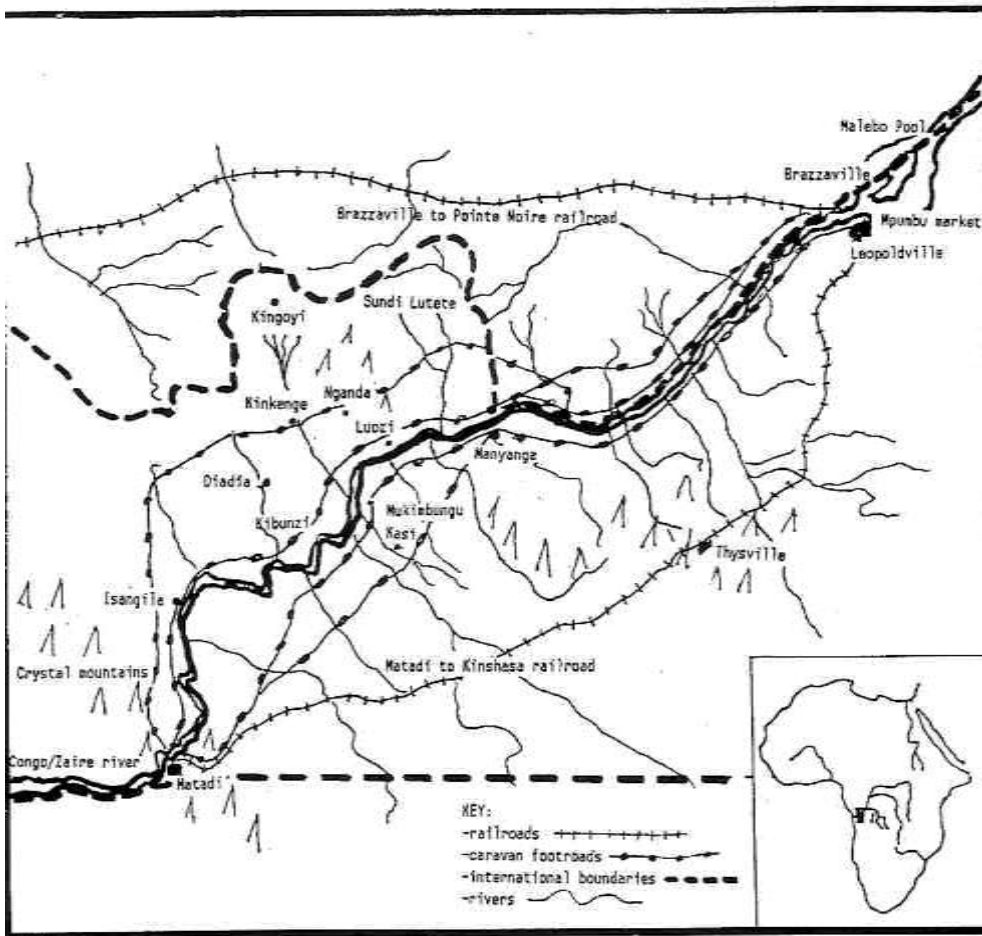
Public health efforts, in the Lower Congo region at the turn of the century, consisted mainly of campaigns against sleeping sickness, bilharzia, malaria, and other endemic diseases. They were led by independent Swedish, American, and British Protestant missionary societies, who had entered the area under the rule (or misrule) of the Congo Free State. After the takeover of the Congo by the Belgian government in 1908, following the Rubber Scandal in which the Free State agents were exposed for their barbaric tactics such as issuing bullets for victims' cut off hands, the stage was set for the colonial government to build a long-term policy of health. In the Lower Congo, from 1910 to 1925, missions were free to do health work as they wished; from 1925 on they were co-opted to serve in a coordinated state policy for the eradication of major epidemics. By World War II public health policy and intervention was being shaped by the Belgian colonial government and carried out through, and with the expected collaboration of, mission societies. Public health had become a tool of colonial government for the control of dissent, moving populations into settlement patterns in keeping with government interests. Missionary medicine became increasingly curative and institutionally centered, although there was some movement toward the initiation of health promotion, in the form of well-baby clinics.

The case of the Swedish Covenant Church Mission (Svenska Missionsfoerbundet, SMF) in Lower Congo is instructive in that early medical mission here took up the challenge to do public health, that is to systematically combat the major epidemics of sleeping sickness and widespread bilharzia infestation, and to create an infrastructure of awareness at the village level, and measures against, the major sources of disease. That the SMF did this in a region that had been seriously affected by depopulation resulting from the trade caravans of the slave era, and where early colonialism recruited porters for its entry into Central Africa, and laborers for the construction of the first railroad of Equatorial Africa--from Matadi to Kinshasa--and in the process lost dozens of workers to these same diseases, is to its great credit, and places the SMF in the company of those mission societies that were definitely part of the solution of healing rather than the problem of disease in early colonialism. It was truly a "daybreak", as an SMF publication described its work.³⁷

This paper examines the contrasting manifestations--mission and colonial--of biomedicine in the Lower Congo from about 1880 to 1930, the period during which colonialism launched commercial ambitions at terrible costs to human life and health. This case offers the anthropology of health and health care a fully-blown instance for analysis in the midst of profound and long term change.

³⁶ This paper was first given in the panel on "The History and Practice of Missionary Medicine," American Anthropological Association Annual Meetings, Los Angeles, Dec. 2-5, 1992

³⁷ Sjoeholm, W. and Lundahl, J.E. Dagbraekening i Kongo: Svenska Missionsfoerbundets Kongomission. Stockholm, 1911.



Health in "the Heart of Darkness"

The Congo/Zaire river from its mouth at the Atlantic ocean, is navigable for about 100 miles to the port city of Matadi (see map above). Just east of this point the river rises rapidly through a series of rapids until it reaches another level stretch, at Isangila, and widens out at places to two kilometers across. This stretch is navigable eastward to Manyanga, the site of the old market that used to provision caravans. The river rises through another series of rapids until it broadens out in Malebo Pool between Kinshasa to the south and Brazzaville on the north. From there it is the sluggish broad river whose main arteries and tributaries drain the entire Congo Basin, the heart of the continent of Africa.

The Lower Congo has been the gateway to Central Africa over much of the past five centuries, and is of special interest regarding the health of inhabitants of the conduits: caravan routes, railroads, rivers and ports, as seen in Map 1. Until colonial and western mercantile interests constructed railroads from Matadi to Malebo Pool in the 1890s, and westward through French Africa to the Atlantic coast at Pointe Noire at the turn of the century, Central Africa was in contact with the rest of the world via footpaths that were trodden by porters carrying loads on their heads from Mpumbu market at Malebo Pool to coastal ports in Angola at Ambriz, Ngoyo, Boma, Kakongo, Ngoyo, or Loango. Large canoes plied the rivers: from Mpumbu market at Malebo Pool a thousand miles upstream in the entire Congo river basin, and from Manyanga to Isangila in the Lower Congo.

The riverain and overland caravan routes along the Congo river were heavily travelled from the 17th century on. This early mercantilism was at once lucrative and devastating to communities along the trade routes: the caravans provided a market for local agricultural produce and portage laborers; but since the trade also included the slave trade, a variety of local people such as criminals, antagonists in feuds, and debt pawns were likely to end up in the middle passage to the Americas. By the 18th century up to 15,000 slaves were being brought overland to the coastal ports of Congo every year, many coming from the deep interior via the Market at Malebo Pool, others from Lower Congo. Geographer Gilles Sautter summed up the health impact of this mercantile history in Lower Congo by noting that population levels had declined by about 50% from the sixteenth century until the early twentieth century.³⁸

Beginning in 1890s, the colonial scramble for Africa hit the Lower Congo river area particularly hard. At the Berlin Conference of 1884-5, the Congo Basin was given to Belgian King Leopold II. Lacking the wherewithal to administer a colony, yet aspiring to become a colonial powerbroker, Leopold's personal fiefdom in Central Africa became the Congo Free State. His administration consisted of opportunists and mercenaries from the entire world. Economic development was launched by concessionary companies who had full reign of the regions granted them.

At first, they used the caravan trails to reach Malebo Pool from where they could continue by boat upcountry. Henry M. Stanley has a notoriety locally because of his role in moving overland through this region the metal pieces of the first riverboats that were to ply the Congo above Kinshasa.³⁹ Joseph Conrad's brooding *Heart of Darkness* recounted his journey in 1890 with agents of the Free State through this region, including the trek with a caravan of sixty porters from Matadi to Kinshasa, and from there on a riverboat up the Congo, in the employ of the concessionary company the Societe Anonyme Belge pour le Commerce du Haut-Congo. Conrad describes the sickly porters, the abandoned villages, and the "horror of it all." Of a Matadi construction site, he wrote:

A slight clinking behind me made me turn my head. Six black men advanced in a file, toiling up the path. They walked erect and slow, balancing small baskets full of earth on their heads, and the clink kept time with their footsteps. Black rags were wound round their loins, and the short ends behind waggled to and fro like tails. I could see every rib, the joints of their limbs were like knots in a rope; each had an iron collar on his neck, and all were connected together with a chain whose bights swung between them, rhythmically clinking. ...all their meager breasts panted together, the violently dilated nostrils quivered, the eyes stared stonily up-hill. They passed me within six inches, without a glance with that complete deathlike indifference.⁴⁰

And of the caravan trek from Matadi to Kinshasa:

Next day I left ...with a caravan of sixty men, for a two-hundred mile tramp. No use telling you much about that. Paths, paths, everywhere; a stamped-in network of paths spreading over the empty land, through long grass, through burnt grass, through thickets, down and up chilly ravines, up and down stony hills ablaze with heat; and a solitude, a solitude, nobody, not a hut. The population had cleared out a long time ago. Well, if a lot of mysterious niggers armed with all kinds of fearful weapons suddenly took to traveling on the road between Deal and

³⁸ Sautter, Gilles. *De l'Atlantique au fleuve Congo: Une géographie du sous-peuplement*. The Hague, 1966.

³⁹ Stanley, H.M. *Through the Dark Continent*. New York, 1879.

⁴⁰ Dean, L., ed., *Joseph Conrad's Heart of Darkness*. Englewood Cliffs, 1965.

Gravesend, catching the yokels right and left to carry heavy loads for them, fancy every farm and cottage thereabouts would get empty very soon. Only here the dwellings were gone, too. Still I passed through several abandoned villages. There's something pathetically childish in the ruins of grass walls.

Day after day, with the stamp and shuffle of sixty pair of bare feet behind me, each pair under a sixty-pound load. Camp, cook, sleep, strike camp, march. Now and then a carrier dead in harness, at rest in the long grass near the path, with an empty water-gourd and his long staff lying by his side. A great silence around and above.⁴¹

The railroad project from Matadi to Kinshasa decimated the countryside further, as population was rounded up to work. Up to 8,000 workers per year were drawn from villages in the region, of whom often less than half returned. Entire communities fled northward to the hilly border region between the Belgian and French Congo.⁴²

For a time a virtual state of war existed between some of the African communities in the middle Lower Congo and the Free State government. Mainly the records of the Swedish missionaries permit a glimpse today of the resistance that was waged over taxation and forced labor recruitment. In 1893 Swedish missionary Borrisson wrote that Free State agent Rommel set up a station south of the Congo river at Kasi (see Map 1) to "recruit" labor for the railroad project. His technique to force men to work was to capture their wives and children and hold them ransom. The savagery of this tactic provoked an armed attack by the local community, and Rommel's death and that of some of his helpers.⁴³ Leader of the rebellion, chief Nzansu, notified the missionaries that they were not in danger. Of course, reprisals by the state followed. At Nganda, north of the river, a recruitment post was set up as well. There too, under the leadership of one Mbonza, a state agent was killed, which led to reprisals, further attacks, and burning of villages and destruction of fields. Entire regions became empty of villages; some relocated to within close range of the missions out of a sense of greater safety from the depredations of the Free State.⁴⁴

Carving out the railroad through the Crystal mountains east of Matadi, and oater through mountainous near Thysville, was particularly treacherous for workers, who were forced to work long hours removing stone under adverse conditions. Dysentery, malaria, sleeping sickness, exacerbated by hunger, took their toll. The memorial to the heroes who died for civilization, that is the Europeans who died for the railroad, includes several hundred names. The thousands of Africans who died on the project are not listed. A contingent of Chinese workers was brought in to complete the work because it had become increasingly difficult to recruit local workers.

In any event, reports of atrocities in the Congo by independent observers⁴⁵ had by 1908 so embarrassed the Belgian king in the international arena, that the Belgian parliament literally confiscated the territory of the Congo from Leopold. While some concessionary companies found their activities curtailed, others continued as before. Some agents were asked to leave, others continued, as was the

⁴¹ Conrad, *Heart of Darkness*, pp. 14-16.

⁴² Dupont, E. *Lettres sur le Congo*. Paris, 1889.

⁴³ Axelson, S. *Culture Confrontation in the Lower Congo*. Falkoping, 1970

⁴⁴ Axelson, *Culture Confrontation*, p. 264

⁴⁵ Lagergren, D. *Mission and State in the Congo, 1885-1903*. Uppsala, 1970

case with agent G. Bolau who had been "chef de poste" at Luozi on the Congo river between Isangila and Manyanga.

Belgian colonial government takes charge

In 1909 the Belgian Bolau returned to Luozi, on the Congo river midway between Matadi and Leopoldville, to find that his headquarters had been completely pillaged by the local Africans. Doors and hinges had been removed from all the buildings. Furniture, tools, tables, chairs, hoes, machettes, storage chests, had all been stolen. His inventory of what remained included long saws, a dozen metal sheets from a boat, the drill for rivet holes, and other metalworking instruments used in boat making. The smithing bellows, shovels, oil barrels, were gone. A boat, which had been put in the protection of local villagers, could still be used. Bolau wrote in his report that he would live in a remaining mess hall initially, and his Africans could live in a grass thatch house.⁴⁶ Bolau, now working for the Belgian colonial government instead of the Congo Free State, began to make trips into the interior to establish a census base for taxation, to try to connect up with the prior Congo Free State "chiefs" who had been given medallions. These mpalata chiefs, as they were called (from the phonetical transformation of medaille) were now being threatened physically by their own people. Several villages along the northern border had moved into French Congo to escape Free State and Belgian colonialism. Many mpalata, called by messenger to report to Luozi, didn't bother to show up to bring their tax revenues.

The agents' reports from 1909 on offer a picture of the state of the health and wellbeing of the region prior to the effective imposition of the second colonial government. Although the paths were well kept, except parallel to rivers where people use canoes to travel, and streams were traversed by bridges, many villages were unswept or even overgrown with tall grass, giving the inhabitants the chance to flee when he did the agent did his tours of inspection. The women are at work in the fields and the men away in Matadi or French Congo selling their animals to have money for the tax. In 1911, Bolau reported that the mpalata in chiefdoms of the northern region, where local political structure had been decidedly acephalous, have very little authority over the inhabitants. The people still fled their villages when he arrived; the mpalata colonial chief would go into the forest to look for the people, but they would shoot their guns at him. One messenger recruiting workers for the port project at Boma was threatened with death; a chief working closely with the colonial government was assassinated. An entire region in the Manyanga highlands for several years kept such messengers and tax collectors at bay through force of arms. Following an ambush of the colonial finance officer Mr. Driesen, who was registering the population and collecting taxes, the state's reaction was to launch a "punitive expedition" in the region where people hid themselves in the tall grass and forest, and to open another state post in the midst of the recalcitrant area. Several additional colonial officers came to help out, and for a time around 1912 maintaining a kind of military occupation. By 1913, the officer reported that the hostilities had abated.

After this initial repression of the population, the local administration began, in 1916, to keep a political report of "l'etat d'esprit" of the population, and of the major activities of government.⁴⁷ The trade economy continued much as before, with caravans of porters providing the major means of transport. In 1917 the government recruited 400 porters for the Mayombe region, and there were still no

⁴⁶ Etat Independant du Congo, Dist. de Matadi, Poste de Luozi, Mod. B.I: Rapports Politiques, p.3, "Rapport sur la reprise du Poste de Luozi." Luozi State Archives, 1909.

⁴⁷ Registre des Rapports sur l'Administration Generale. Belgian Colonial Government 1916.

merchants in the Luozi territory. The population resisted imposition of cash crops, in this case Aleas fibre, a kind of sisal, and food crops in certain areas.

Epidemics of flu, dysentery, and malaria, in addition to endemic sleeping sickness, raged in the area. Workers on the railroad project northward from Matadi to AngoAngo in the Mayombe forests fled to their villages to escape the flu pandemic of 1918, in the process spreading it further. The colonial response was to round them up and force them to return.

Careful field research by this author in the north Manyanga established that in the early decades of this century villages had taken to living in dense forest near streams and rivers, instead of the typical open air hilltop sites preferred. Such residence in the habitat of misquitos and tsetse flies undoubtedly contributed to the rising rate of disease.

These adversities were followed by widespread anti-witchcraft and messianic movements among the Bakongo in 1921. Chiefs sometimes had their own prophets, bangunza, which prompted further military expeditions through the area to remind the natives of who was boss. Such was the public administration of the early Belgian colonial government.

Only by 1930 had population begun to increase in those areas of the caravan trails, and the regions that served as the source of labor for the railroad project.⁴⁸ This increase reflected mainly the northern Manyanga region. Well into the 1960s regions on either side of the stretch on the Congo river between Matadi and Kinshasa, alongside the still wide portion of the river between the two cataracts, there was an eerie emptiness. Only occasional hilltop villages could be seen. Along the lowland rivers in the Western Manyanga, there remained almost totally deserted areas. Maps of population density on the north bank of the Congo/Zaire made in the 1960s show that regions along the river have from none, to at most 10 inhabitants per square kilometer, whereas in the highlands areas distant from the river, population density is near 35 per square kilometer.⁴⁹

With this background we can turn to the story of the medical work of the Swedish Covenant Mission that in 1888 entered this empty, or emptying, zone, to minister to the needs of the people devastated by the multiple scourges of the slave trade in the midst of raw mercantilism, local wars, epidemics of malaria, sleeping sickness, and early colonialism in the Congo Free State.

Swedish Covenant Mission medicine in Lower Congo

The Swedish missionaries of the Free Church persuasion--Svenska Missions Forbundet, SMF--arrived in 1881, and founded stations at Mukimbungu, situated just south of the calm stretch of the Congo river that began at Manyanga and extended to Isangila. It was, unfortunately, a major site of sleeping sickness and malaria suffering. The same could be said for the other SMF station, at Nganda, north of the river in the Luala valley. There were no medical people at first, and many of the early missionaries died and are buried in the cemeteries of these two stations. Several nurses began medical work in the 1880s. The first Swedish medical doctor to work in Congo was the English-trained Dr. Walfridsson, who upon arrival at Mukimbungu in 1891, was able to spend only two years before he died in 1893. A diplomed pharmacist, J.G. Palmaer, not to be confused with the great Gustav Palmaer who would

⁴⁸ Trolli, G. and Dupuy, E. Contribution a l'etude de la demographie des Bakongo au Congo belge 1933. Fonds Reine Elisabeth pour l'Assistance medicale aux indigenes du Congo Belge (FOREAMI). Bruxelles, 1934.

⁴⁹ Nicolai, H. Luozi: Geographie regionale d'un pays du Bas-Congo. Bruxelles, 1961.

advance the medical work later, lasted until 1897. He was succeeded by Berthold Hammar who built the first mission hospital at Nganda near Luozi shortly after the turn of the century, but died after one term, in 1908, as the Belgian colonial government was replacing the administration of the Congo Free State.

Dr. Gustav Palmaer arrived in 1911, and worked in Lower Congo until 1929 as the head of the SMF medical effort. He studied in Leopoldville to develop methods in the fight against sleeping sickness and was the first to really attack the disease in SMF territory. In 1920 the Governor General of the Congo invited all the missions to help in organizing a "Service auxiliaire de l'assistance medicale aux indigenes" and the SMF medical service took up the surveillance of regions around their posts. In 1926 30,000 people were examined and 1,024 cases of sleeping sickness treated, by the SMF medical services. (According to local governmental surveys, in 1924 Kibunzi treated 1,217 sleeping sickness cases out of a total of 14,791 patients.) [11]. The percentage of sleeping sickness infected populace had diminished to about 3% from the 5% it had been some years earlier. Palmaer created a children's feeding service in 1924. He founded the Kibunzi hospital in 1923, with the abandonment of the Nganda hospital and station, and its nursing school in 1926. Dr. Wiklund, replacing Palmaer in 1929, collaborated with the government service Fonds Reine Elisabeth pour l'Assistance medicale aux indigenes du Congo Belge (FOREAMI) in the fight against sleeping sickness. His successor, Matteson, helped to bring down the incidence of the disease to its present almost insignificant level. FOREAMI could withdraw its campaign in 1936; Nganda (in 1913) and Diadia (in 1908) were abandoned⁵⁰ because of their unhealthy setting, and the work in the north was opened at Sundi Lutete.

The state's interests had been served by special concentration on sleeping sickness. But other diseases and infestations such as bilharzia and other waterborne diseases, that could not be treated in hospitals, were of concern, at least to the missions. From 1927 until 1932 an annual health survey was carried out in 64 villages in five districts or colonial chiefdoms by first Palmaer and then his successors and colleagues of the SMF.⁵¹ Until 1938 the Swedish Mission carried the major load for public health in the entire region around Kibunzi.⁵² "Hygiene maps" were kept of villages, indicating location (whether in tsetse infested valley or hilltop), showing water sources, bathing places (whether infested with bilharzia), paths, numbers and types of houses (grass, mud, brick), numbers and type of toilets, and the overall hygienic condition of village--e.g., "assez propre,"⁵³ Also listed were the names of clans, and nearby abandoned village sites reflecting the impact of labor recruitment, resistance wars, or moves for health reasons. Apparently these surveys also identified infection rates of major diseases including sleeping sickness and bilharzia.

These systematic public health programs that had been initiated by the Swedish Mission had been for the most part given over to the Belgian Colonial State by 1938. But, as I shall stress later, the effect of a given program varied significantly depending on whether it was administered by the mission or by the colonial government. In one area, however, there was unanimity between the missions and the colonial government, both of which forced upon African society a totally uncharacteristic approach to handling sickness, namely to isolate the sick in a separate society.

⁵⁰ Trolli, G. and Dupuy, E. , p. 48

⁵¹ Registre de Recensement Medicale, Kibunzi Hospital Documents, 1932.

⁵² L'oeuvre medicale de la Svenska Missions Forbundet au Congo belge, Rapport annuel 1938. Matadi, 1939.

⁵³ Vilen, Dr. Registre d'Hygiene des Villages de la Chefferie de Kibunzi. Kibunzi Hospital Records, 1936.

The leprosarium: a case of medical and social engineering

Both colonial and mission medical authorities cooperated in developing a unique policy toward leprosy, a disease considered both contagious and stigmatizing in the Judeo-Christian tradition. In 1932 there were only around 900 cases of leprosy in the entire Lower Congo region--the highest being in an area near the river--thus an endemicity rate overall of 0.17% [15]. As elsewhere in colonial Africa and Asia, lepers were isolated in leprosaria. The SMF opened its colony near Kibunzi, where the medical director could oversee the treatments, admissions and, rarely, releases. The colonial government arranged land for the lepers to cultivate; a hunter among them was authorized to use a gun to find game. A society unto itself developed, kept semi-isolated; violators were punished by the state for "endangering" others. Infants who were born to mostly common law couples in the leper community were taken from their parents at an early age and given to relatives to raise. Colonial and medical policy advocated that they, and the entire population, were to be vigorously educated on the nature of leprosy; they were to be strictly supervised so as not to come into contact with non-infected persons. In one instance an entire village moved, leaving its lepers behind. The SMF's leprosarium was finally dissolved in 1969 and the twenty or so inhabitants were encouraged to go home, although they had become so accustomed to their life and society together that they disbanded reluctantly.

Health care and colonial repression

The Belgian colonial government struggled to gain control over the health issues in its vast territories, but this came only with a massive, and continuing, repressiveness that the subjects, or victims, resented. The FOREAMI "franchised" campaign was an effort, limited to the Lower Congo, to coordinate public health initiatives and the treatment of major epidemic diseases. Even so, it utilized the energies and the infrastructure established by the missions, in particular SMF.

Belgian colonial administration was unable to cover the front and maintain an adequate public government in other respects. The early colonial judicial system consisted of the traditional reconciliation meetings. Anti-witchcraft rituals and prophet movements erupted repeatedly, only to be put down with force. Finally in the mid-30s did the Belgians initiate judicial reforms that resembled British indirect rule.

The colonial struggle against hamlet dispersement was perhaps the most bald instance of health policy serving the purpose of political control. In a 1932 health policy declaration on "Hygiene des villages,"⁵⁴ the health branch of the colonial government recommended stricter control of hamlet dispersement to facilitate health and administration. The Lower Congo and Upper Nsele regions were used as test areas by the Belgian colonial government to enact forced hamlet relocation into larger, administratively compact, settlements. Fragmentation of settlements should be strictly forbidden "because that makes the work of our sanitary agents and doctors physically impossible." The statement recommended that in the case of African chiefs who do not or cannot control dispersion, the colonial government is to intervene directly to deal with the problems. Enforced public health in the form of huge projects to cut grass, the demolition of unused buildings, drainage of marshes, even an imposed village relocation, or other similar mass public works, will induce a spirit of cooperation, the author recommended. Hygiene and public works became the punishment for recalcitrance to colonial authority.⁵⁵

⁵⁴ Fonds Reine Elisabeth pour l'Assistance medicale aux indigenes du Congo Belge (FOREAMI), *Rapport annuel sur l'exercice 1931*. Bruxelles, 1932.

⁵⁵ Janzen, J.M. *Quest for Therapy in Lower Zaire*. Berkeley, 1978, pp. 41-44 for a fuller discussion of Belgian cultural policy in the Congo setting.

Belgian public health in the Congo was as paternalistic and repressive as its overall colonial regime. It never got beyond the level of building a healthy workforce of docile natives. The ideology of the defective or distinctive "mentalite indigene" legitimated a special approach to Africans controlling their access to open and free care, and restricting their participation in the upper level medical professions: physician and public health officer.

An anthropological perspective on mission medicine

The anthropological investigation of mission medicine in this case needs to be made with the understanding that the discourse of biomedicine in the mission was quite distinctive from that in the colonial government, with regard to the health and wellbeing of the African, the "other" of colonialism.⁵⁶ As in Terence Ranger's study of the Universities Mission to Central Africa,⁵⁷ so the Svenska Missions Forbundet of Lower Congo worked within a framework of education and literacy that saw Africans as if not quite equals then at least as full humans, rather than as a labor force in an imperial empire that was supposed to turn a profit. At a time when the Congo Free State was recruiting workers forcibly to its railroad construction project, and the Belgian Congo was imposing the cultivation of cash crops, and people were fleeing into the bush or into the mountains, the SMF was publishing a KiKongo newspaper, *Minsamu mia Yenge* (Good News), with a subscription list of 400 teachers and laymen throughout the region. The SMF's vision for public health was also broader and more progressive than that of the colonial government. In the 1930s, when the government had taken over most public health, the SMF opened what we now call "well baby clinics."

The SMF medical work, despite its self-proclaimed Christian witness in health work, did not come across as religious healing. As Terence Ranger has noted, European mission medicine in Africa, and so in the case of the SMF, was far more secular than the healing that was done in African society. SMF doctors did not collaborate with African healers, in fact they fought them and sought to have them arrested, something the colonial government was not inclined to do unless they were group-organizing prophet-seers.

Biomedicine in this colonial setting was therefore secular and technical. Within these rubrics, it was not a monolithic cultural construct. The differences may not have had so much to do with technical medical concepts, as in the ideology and manner that it was couched in the power relations of colonialism, and the ultimate purpose of health: to create a compliant populace and capable workforce on the one hand, and to engender a healthy population in the other. These differing ideologies informing the same technological character of biomedicine gave rise to distinctly different "health profiles" in the populations affected. Most importantly perhaps, they differed in the degree to which health improvements were picked up and incorporated by the populace. There where enlightened health monitoring and public education was done, where well-baby clinics were introduced voluntarily, the practice of enclosing water springs, digging and maintaining latrines, and keeping settlements free of grass, and keeping children clean and well-fed, became part of the local culture of health maintenance. There where it was imposed as a punishment, the latrines may have been dug but they

⁵⁶ Vaughan, M. *Curing their Ills: Colonial Power and African Illness*. Oxford, 1991.

⁵⁷ Ranger, T.O. "Godly Medicine: the Ambiguities of Medical Mission in Southeastern Tanzania, 1900-1945" pp. 256-282, In *The Social Basis of Health and Healing in Africa*, eds. Steven Feierman and John M. Janzen. Berkeley, 1992.

were not used. Health scholarship and practice clearly has to factor in the sociopolitical and cultural dimension of health behaviors to deal effectively with variables such as these, even within the same medical system.

Scholarship today also shows us that there were some broad health and demography issues in play at the turn of the century, such as the causes and patterns of population decline.⁵⁸ The gradual decline of population was shared with other regions of coastal Africa, and the reasons for it, namely slavery, warfare, and high rates of sickness, are not exceptional. What is of more interest perhaps is the causes of low fertility especially in the so-called low fertility belt along the Atlantic coast of Equatorial Africa, that continued to be reflected in low population density.⁵⁹ Within African medicine, this condition was reflected in numerous fertility enhancement cults and treatments in Western Congo, Northern Angola and Western Zambia. Current understanding points to both venereal diseases and general poor health as the reason for high infertility rates. Lingering infertility may thus be yet another of the longterm costs of the coastal trade of earlier centuries.

⁵⁸ Feierman, S., and Janzen, J.M., "Population decline and rise", pp. 25-37, In *The Social Basis of Health and Healing in Africa*, eds., Steven Feierman and John M. Janzen. Berkeley, 1992.

⁵⁹ Caldwell, J.C. "The social repercussions of colonial rule: demographic aspects," pp. 458-486, *General History of Africa VII: Africa under Colonial Domination 1880-1935*. Berkeley, 1985.

Chapter 5

SHEIKHS, SAINTS, AND BARAKA: SUFU HEALING AND SOCIAL CONSTRUCTION IN CENTRAL SUDAN⁶⁰

Introduction

The Sufi sheikh is a prominent figure in public life in Central Sudan, as a founding saint, the former leader of a local congregation and community, or as a charismatic figure in his own right, the bearer of ancestral *baraka*, mystical power, inherited from a previous generation, and ultimately, a founding saint. Many sheikhs' *maseed* or settlements in Central Sudan, include a mosque, a hospital, a school, and often markets, dwellings, and other important institutions of public welfare.

The Sufi sheikh in his *maseed* is part of a much more complex array of health bestowing figures and institutions in the Sudan of the early 21st century. Not only is the Central Sudan a multi-cultural society, reflecting the presence of migrants—economic opportunists and war-displaced—from the wider Northeast African region, it is historically and religiously diverse. Scholars who have sketched the historical and contemporary diversity of healing in Central Sudan⁶¹ have mentioned Pharaonic, Christian, Nilotic-African, "indigenous," Arabic, West-African Islamic, Egyptian, Ethiopian, and biomedical influences on the total medical culture. Precisely or approximately where or what in this mix is "Sufi"⁶² remains to be defined, as does the incorporation into self-avowed Sufi ritual and healing of elements from these other sources.

Yet Sufi identity is prominent in the sheikhs of Khartoum and environs—representing in order of prominence, Qadiriya, Sammaniya, Tijaniyya, and Khattuniyya, and Khalwa Islamic schools. The clientele is huge. This paper will present images and information of sheikhs visited by Janzen in 2004 in Khartoum, Omdurman, North Khartoum, Wad Medani, and regions between and along the Blue

⁶⁰ For the conference on "Sufi Arts, Rituals, and Performance in Africa", University of Kansas, February 22-25, 2007, at the University of Kansas – Lawrence; presented with Khalid Elhassan.

⁶¹ El Safi, Ahmed. Traditional medicine and its role in health promotion. El Safi explores the characteristics of indigenous Sudan medicine against a brief backdrop of external sources. Prepared for a folklore and development symposium in Khartoum, 1981; Ahmed, I.M., J.J. Bremer, M.M.E. Magzoub and A.M.H. Nouri, "Characteristics of visitors to traditional healers in central Sudan." Eastern Mediterranean Health Journal, Vol. 5, 1, 1999, 79-85; Ahmed, Mohammed Galal M., Website of the Traditional Medicine Research Institute, Khartoum, MAPRI, 2007. www.cta.int/partners/ncr/MAPRI.htm

⁶² El Safi, Ahmed, The External Influences on Traditional Medical Practices in the Sudan. Khartoum, n.d. Chairman, Traditional Medicine Research Institute, National Council for Research, Sudan, reviews Arabic and Islamic influences, Egyptian, Graeco-Roman, Babylonian, Ethiopian, North and West African influences upon Sudanese practices, based on texts, covering hypotheses and theories of influence. El Safi speaks of 15th century Sufi missionaries bringing some practices to the region. For a general overview of Sufi orders, see Trimmingham, J. *The Sufi Orders in Islam* Oxford: Clarendon Press, 1971. For other studies of Islamic healing in Africa, these works are exemplary: Abdulla, Ismail H. "Diffusion of Islamic Medicine into Hausaland." Pp. 177-194; and Greenwood, Bernard, "Cold or Spirits? Ambiguity and Syncretism in Moroccan Therapeutics," pp. 285-314, in *The Social Basis of Health and Healing in Africa*, ed. Steven Feierman & John M. Janzen, Berkeley, Los Angeles, London: University of California Press, 1992; Fassin, Didier. *Pouvoir et maladie en Afrique: Anthropologie sociale dans la banlieue de Dakar*. Paris: Presses Universitaires de France, 1992, pp. 199-204 *Connaissances islamiques*..

Nile. A profile of individual sheikhs, their centers, and generalizations about what they have in common, and interpretation of the sheikhs and their centers by Elhassan will provide the basis for a portrayal of Sufi healing in Central Sudan.

The central point that will be argued is that in attempting to heal individuals, Sufi Sheikhs in Central Sudan build communities through the wider work of the *maseed* over a lifetime, and over generations within the particular *baraka* line. Conversation with my hosts and guides⁶³ emphasized that the sheikh is considered a leader because he settles disputes, is respected in general, and can read the Koran. The remainder of this paper includes extensive selections from Janzen's fieldnotes or letters (in italics), interspersed with introductions and discussions, or review of scholarly literature.

Sufi Sheikhs

***Sheikh El Boura'ai** and his son **Sheikh Suilman** head the center of Riyhad near the airport. As many Sufi centers, according to Abu Baker, successful and revered Sheikh Boura'ai and his sons (of a family of 25 children from four wives) have a large following in a number of centers in several towns. Tonight we would see one of the sons, Sheikh Suilman, presiding.*

***Sheikh Abdulla of Taiba** ...is the third or fourth generation Sheikh in this place, he and his father built the mosque; his father and grandfather are buried in the tomb visible from the road, the line goes back to the tomb of Sheik Josif at the Fifteen Tombs.*

Has hearing room in his house, a traditional small tight set of rooms with an inner personal room. Throngs of people eager for their hearing were pushing and shoving into this tight inner room. After leaving our shoes at the entrance door, we were ushered through this throng and past the hearings into the inner sanctum where we waited for the Sheik to come talk to us. He took a break with us and agreed to let us watch and to take pictures. We chatted about his work and the genealogy of his line. Photos of his father, uncle, grandfather (whom they called the Abdulla the Black because of his skin color).

[Maulid square Omdurman] *The Maulid is a ten-day birthday party of prophet Mohammed. In many mosques and centers tent cities are set up like fairs, ... This scene is repeated in every city and village around the Islamic world. [**Sheik, Hassan,**] praying in the front row, had given up a university professorship in economics to succeed his father in leadership of a maseed. Abu Baker said these displays were not competitive, yet they were all on display promoting their unique way of singing and praying, but promoted the notion of Sufism as a united movement that fosters distinctiveness of each Sheikh and community within the whole of Islam.*

The Maseed

⁶³ I am immensely indebted to Khalid El-Hassan and Saadia Malik for arranging the trip to Sudan, and for introducing us to their extended family and to the members of the Republican Brotherhood who facilitated all aspects of the visit, including contacts with healing Sheikhs. In particular I wish to identify I. Siddig for his generosity in lending his vehicles to the cause of our visit, and Abu Baker Malik for his inexhaustible networking and driving on our behalf.

The *Handbook of the Traditional Medicine Research Institute* in Khartoum calls the maseed "... a complete and integrated health, religious, educational, and social institution"⁶⁴ in which the Sudan abounds. This is illustrated in several maseed we visited in 2004.

[Riyadh] *The relatively newly built complex [of Sheikh Suilman] included a mosque, various meeting halls, a clinic, a room for the sheikh's reception and healing of followers to give them their blessing, also a kitchen for feeding the poor, a vast outer courtyard, and a shaded corner where a Koranic school is held for the poor boys who live in the Center.*

In [North Khartoum] Sheikh Mohmed Khier Ibrahim directs his Islamic school and center but specialized on healing. The Sheikh's operation included an Islamic school for 200 orphan boys with the required dormitories, kitchens, and classrooms, open courtyards for prayer, a prayer tower, a mosque, [a clinic,] and an Islamic healing center. He introduced us to his private quarters, sat down on a low bed-like bench, asked us to be seated across from him, had his assistant bring us bottled drinks and a little later tea, and [we began to talk through Abu Baker's expert translating].

[Sheikh Abdulla of Taiba's maseed] includes, in addition to [a school for 400 students], a "hospital", where we saw a girl who had been unconscious and in daily seizures seated with her mother, and another child who had been unable to walk, who now seemed somewhat improved. In another building we saw scribes writing Koranic verses on slips of paper and tablets for the healings. We walked past up to 15 violent mentally ill patients seated on beds under shade trees, their feet chained to the ground, and in a few cases their hands chained as well. The caretaker showed us in great detail how they were well fed and cared for. [One had just been fed and showed us his chains himself.] Another was incoherent, babbling, said to be very violent. Much was made of the diet that they receive: no salt, no spices, no meat, just basic mush from dura, to calm them down. (I did not try to figure out what the classificatory or nutritional logic of this might be.) We walked past the mosque that had been built by Abdulla and his father, and on to the tomb of his father and grandfather, where several people were praying, and where three musicians were playing their instruments in a happy melody.

Sheikhs and Dervishes

The sheikh known as the Mahdi--the promised one-- who led the resistance against the Turkish colonial rule in the 1880s is memorialized in this the most prominent building in old Khartoum (Omdurman). The Mahdi died shortly after independence. He was succeeded by the Khalifa, from whose house this picture is taken. The Mahdist state survived until the British conquest of 1898.

In contemporary postcolonial Sudan [the mahdi's tomb] and the first chalice residence overlooks a vast square at the site where history had been made, where Sudanese nationalism had been born in a bloody confrontation with British colonialism. The tomb and the Khalifa's house are interpreted within the relationship of the Sheikh to dervish. In the door to the khalifa's house stands [an effigy of one of the soldier-dervishes], a prototype for the warrior-mystic.

⁶⁴ El Safi, Handbook, 1983, p. 2.

The Sufi religious movement of the Mahdi and his dervish-warriors is held out as a kind of prototype for the nation, at least in its beginnings. The current government—the Islamist National Front--uses this base as an ideological legitimation, a move that is met with widespread criticism.

One individual we met accepted and praised the varieties of Sufism with their local adaptations--Tijaniyya, Buraniyya, Qaddariyya--whatever they might be. All emphasized the transformation of the individual within a local society and community, among the followers of the Sheikh. The National Front, on the other hand, with their use of killing and arbitrary application of medieval sharia, were simply a corrupt gang who abused the name of Islam, which is a religion of peace. One of the sheikhs featured here had been requested to join the National Front when they took power, but he had refused. He told them they could come to him for blessing, but he would not join them. That is why our informant respects him and his line of congregations.

The relationship between the Sheikh, who carries the baraka, and the dervish, who is the warrior/dancer, remains to be further explored, especially in the focus on Sufi ritual and performance.

Sheikhs, Devotees, and Clients

Abu Baker told us that his esteem for Sheikh El Boura'ai went back to his own days of unbelieving and how El Boura'ai's miracles (baraka) had turned him around and that he was now a believer in the Sheikh's powers. He told us how a famous Sheikh's pupils are taught and gradually are given more and more responsibilities, until they themselves become Sufi Sheikhs. In this case Suilman, son of El Boura'ai we were about to see had achieved such full powers and was the one in charge of the day's ceremonies. Said Baker, if the Sheikhh is living, you go to him with your troubles, and to receive blessing. If he has died, you make a pilgrimage to his tomb. We were about to visit the son of the still living Sheikh. [Sheikh Suilman] was receiving people with various problems. One woman brought a sick child; another brought a plastic container of medicines; young women; men; husbands and wives, all came with prayers and requests. After receiving them, often with a handshake or some kind of touching gesture, he would bless them. He would extend both hands out with upturned palms for a few seconds to indicate to gesture that the blessing of God was present; then he would clap his hands, and in a sweeping motion wipe both hands down across his face. Others in the room would do the same, as would those receiving the blessing. Often the Sheikh would then give the supplicant slips of paper with Koranic writing on them.

[Sheikh Abdulla of Taiba has his hearing room] in his house, a traditional small tight set of rooms with an inner personal room. Throngs of people eager for their hearing were pushing and shoving into this window-less string of three rooms: a waiting room, the inner room accessible by a low narrow door, and the inner sanctum, also accessible through a small low door with no other outlet. We were ushered through this throng and past the hearings into the inner sanctum where we waited for the Sheikh to come talk to us.

Dikr: Proclaiming the Thousand Names of God

Before us a circle of men in white caps and robes were already doing the dikr dervish ceremony. A smaller group of about twenty, led by one or two dervish-choreographers, were moving slowly but

rhythmically around the outer ring of the circle, in accompaniment to drumming. One in particular stood out, dressed in a red and green robe and cap carrying a hand full of prayer beads. This inner group would stop periodically in their circular movement and begin another song, which the outer circle then repeated or to which they had a simple response phrase. Some of the songs were in “dervish” speak, but others were about praising God, or Sheikh El Boura'ai encouraging them to worship God.

*After sunset, but while it was still light, the sheikh closed his hearings inside to join the dervishes. He now led the **group of twenty** or so dervishes around the circle, with ever more intensive and demonstrative whirling and singing in the ceremony. According to Abu Baker, this intensity expressed the baraka of the Sheikh, as it spread through the men and even to the women. One woman had collapsed in a trance and lay flat on her face. She was gradually brought to consciousness by other women with sandalwood incense in a small burner. The Sheikh, after **half a dozen circlings with the dervishes**, now led the group to the north side of the courtyard. Women and children now joined him in one mass of the congregation, perhaps several hundred strong. They all together went through the gestures of blessing, with hands raised high as the Sheikh spoke the corresponding words. Then he led in the clap, and all clapped, followed by their hands onto their faces. The assembly divided again as the men gathered in the northeast corner of the courtyard for prayer, facing Mecca, while women and children retreated to the south side to complete preparations for the meal. Although most women also participated in the prayers at a distance, wherever they were at the time.*

The Republican Brotherhood practices **a very different kind of Sufi worship**—which Khalid Elhassan and Saadia Malik have presented earlier. Meeting in homes, as a congregation of men, women, and children, they sing ishnad ballads and share a meal together. Yet in many respects the idea of the maseed around a Sheikh is also present.

We went on to the meeting place of the Republican Brothers at the home of Sheikh Abdellatif Omer Hassaballa in Omdurman. We were ushered through several rooms with beds standing around, and into the courtyard where the “congregation” was seated waiting for us to arrive so they could begin. We were ushered to two chairs at the center of the assembly. Men were seated to our left, women to the right, and children on mats in the middle. This rectangular form of the worship of the RBs reminded us of the shape of early Mennonite assembly. It would be the first of other resemblances. A small table was put before us and water and pepsi were set before us. The sheikh began with opening remarks from his seated position. He welcomed us. Then he called on the first singer to begin.

The large part of the service is devoted to singing of inshad, or spiritual songs, without accompaniment, songs that we were told are a combination of old Sufi songs and newly composed songs from among RBs. Perhaps we should speak of hymns. This night there were about five song leaders, men and women, one of the latter being a prominent blind woman who performs publically and has commercially recorded tapes. In each inshad, the singer opens, and invites others to respond. Each new phrase is led out by the head singer and repeated by the congregation in a pleasing and interesting melody and rhythm that features the leader's creative talents. Frequently the leader would be snapping his or her fingers, or tapping a foot to keep the tempo going. But there were no drums here, nor very demonstrative bodily rhythm shown. Rather, the singing was intense and one could see on the serious yet joyous faces of lead and other singers as they were sharing with one another their deep faith and their common suffering and joy. Presently the leader would come to a stop and seemingly everyone knew which refrain closed the hymn. One particular hymn had a somewhat more

rousing finale, with repetitive rhythmical singing of the phrase “Allah a –Allah a –Allah a” until the leader and followers abruptly stopped.

Shortly after the closing of the service tables were brought out and chairs were put around the tables. Big round trays filled with dishes of delectable foods of various kinds, and bread, were brought out on to the tables, and people gathered for the common meal in groups of six to eight for each tray.

Baraka, Medicines, and Healing

***Sheikh Mohmed asked us first** if we were believers. We explained that we were, and how we participated in Christianity, prayers at mealtime, church on Sunday, singing and prayer in services, and so on. He said it would be much easier to talk to us if we were believers, since he emphasized both religious and medical healing, in that order, with his clients and his students. I told him that I was aware of two broad streams of Islamic healing, that called “medicine of the prophet” and Yunani, or Greek, medicine. Did he know of these, and which did he practice? He replied that the Greek version had not come to him, that he practiced medicine of the prophet, but also his own innovations. When asked where he learned his art, he noted that he had learned it from a master Sheikh. He noted four aspects to this work: Reading from the Koran, copying down prayers or verses onto leaves of a sacred plant mentioned in the Koran which he gave to patients; burning the prayers as incense, and making an infusion or tea to be drunk from the written verses. We were shown the room where an **assistant was copying** Koranic verses onto paper slips and onto the plant leaves.*

Sheikh Mohmed went into a theological discourse on why Islamic healers could perform miracles, that is why they could do effective cures. In the Koran, all humans are equal, in their nature. But there are those who have the gift of healing that God has given them. Not to develop that gift is a grave sin for which the sinner will end in hell. Submission to God through Islam is the most effective way to develop one’s gift of healing. This is where Islam is superior to Christianity and other ways, a more perfect way. Thus God is able to work through the healer, with the Koranic verses and techniques. It is God who heals through the healer, and God who determines whether a given technique will work on a particular patient.

In order to move our conversation forward on common ground I recalled to him my encounter in Tanzania with a healer who had used a book from Egypt that had no cover on it and thus no author’s name. Did that call to mind any author? He immediately answered that indeed there was a famous Egyptian book of medicinal recipes and techniques which was widely used by many healers, not just Islamic ones. I think he offered a name, but I did not record it.

*To see how **Sheikh Mohmed** recognized some current health problems and social issues I suggested that in my work I had studied people in the aftermath of war, both in the Great Lakes region and in America, where a good number of refugees from Africa’s wars and crises had arrived and settled. These people often had terrible memories of their wartime experience and sought to find ways to heal them. Had he experienced such cases? He thought a bit and then said he had received three such cases, of soldiers, that he could recall. They had come to him complaining of inability to sleep and constant anxiety. Two he had given his standard spiritual treatment as described above, and they had been cured. The third individual had not responded to his treatment. He did not elaborate on this, but*

it seemed to fit his earlier statement that God is the one who decides to heal or not to heal through the healer who is submitted.

We talked further [with Sheikh Abdulla of Taiba] about his work and I asked him what the most prominent problem was that people bring to him. Daily aches and pains, or its equivalent, is what he said. I again raised with him the question I had asked the caretaker outside, what he thought caused violence and mental illness. Surprisingly, his answer was almost identical to that of the medical intern outside. Poverty and their situation, their character, bad food. So there was here no mention of spirits, but a social consciousness about the harmful and destructive impact of poverty. I asked him about the number of such patients in his care, perhaps fifteen. Did they all come from the local town, or farther away? He affirmed that most came from elsewhere. Later, someone confirmed that Sheikhs specialize like this, and refer patients to each other.

Baraka and Saints

Sheikh Mohamed's personal chamber was sparsely furnished, but the signs of his role were abundant. A simple rug covered the floor before him, right where his patient/clients would sit for treatment and counsel. The shoes and sandals that were lined up at the door suggested that this was a sacred space, set apart from the outdoors. Behind him, on the wall, hung a large carpet illustrating the Ka'aba at Mecca, beneath which, over most of the carpet, were Koranic verses. The room, as the entire complex, was wired. Overhead there was a ceiling fan, and on the wall a simple lamp to suggest that he spent time here at night. Against the wall stood another bed, fully made with pillows, blanket, and spread. A few books and papers were on the bed. Beneath the bed were several drums for the dikhir. On the opposite wall, facing the carpet with the Koranic verses, was a student's board, a large version of one, wrapped in plastic, with writing over the entire face. Before we excused ourselves, he told us the story of that second bed which he said had been made up but unslept in for twelve years.

He had acquired the bed for the visit by his own Sheikh. Yet before the visit he had died. Ever since he has kept the bed prepared for that visit as a reminder of his teacher. The hierarchy of spiritual gifts, the flow of baraka, was most evident here and suggested an entire worldview around truth and power. I wondered about the place of the drums here in association with his teacher, comparable to drums in Central Africa being the "voice of the spirits."

The spiritual hierarchy of Abdullah of Taiba is especially well demarcated in terms of the [photographs of his genealogy in his chamber], the [tomb-shrines of his parents] and [grandparents] outside of Taiba, and the conscious line he traces back to the tomb of Josef in Abuharaz, a cluster of 15 tombs on the Blue Nile.

How do the modernist reform-conscious Republican Brothers fit into this picture of the Sufi hierophany of baraka-inspired connection to a saint? Let the following illustrate that point.

*We were up early and with bags packed for a night on the road. We joined the Republican Brothers for early morning songs and prayer at the **Sayed Ali Al-Mirghani tomb and mosque**. A good number of the same assembly as the previous night gathered to sing and pray in the tomb of the Sheikh and his wife. Through the doors from the tomb area to the mosque we could see many people at early prayers. Reinhild and I were asked to stand with the group for inshad singing, following which prayers and requests were made at the tomb, one hand resting on the sarcophagus. This Sheikh (ca. 1885 – 1965) was a twentieth Century leader appreciated by Republicans. Abbu Baker said this was because he*

resisted the British, but was so popular that they could not silence or sanction him. Thus he is regarded as both a spiritual leader and a national hero in Sudan—of course, he is said to be a direct descendant of the prophet Mohammad.

Our next destination was the site of Abuharaz or Abuhraz near Wad Madani on the Blue Nile where more than 15 Sufi saints tombs had been built over the years into a unique cluster striking on the landscape. We had left Latfi later than we hoped, but Abu Baker raced against the sunset over sandy half desert tracks through acacia trees at up to 140 kph, and got us to our destination with a few minutes to spare. Our party prayed at the first tomb, of Sheikh Josif, and Izzeladin took some water from the local well and sprinkled it on his new—now very dusty-- car to bless it. Abu Baker instructed us some time ago to make a wish when praying at a tomb, and it would come true.

Conclusion

Hopefully the whirlwind tour of Sufi Sheikhs of Central Sudan will provide enough illustration for further discussion. Many questions remain to be discussed and illustrated. For me this has been a steep learning curve into Sufism begun in Senegal and Tanzania, and into the layered history of the Nile valley begun in two trips to Egypt a while ago. This experience has also suggested some connections between Sudanic Sufism and Kongo Christian prophets' rituals that may have been acquired during their years of internal exile in Ituri under the Belgians.

III. Reading the Signs

Chapter 6

UNDERSTANDING MISFORTUNE AND AFFLICTION: WHY DIVINATION IS SO CENTRAL TO AFRICAN HEALING

Divination in Africa goes hand in hand with healing. That is, divination (a somewhat arbitrary term that is commonly used, along with oracles) is the diagnosis or analysis of a problem or dilemma that usually requires some kind of therapy or resolution. Inclusion of the two aspects in an equation is what Victor Turner had in mind when he combined two short monographs in a republished volume entitled *Divination and Revelation in Ndembu Ritual* (1975), or Maria Teixeira in her book *Rituels Divinatoires et therapeutiques chez les Manjak de Guinee-Bissau et du Senegal* (2001). Yet the concrete relationship between divination and the therapeutic or ritual followup may vary. It may be unitary, that is it may be done by one and the same specialist or group of specialists. Or, in a more common approach, the divination is separate from the follow-up. Many diviners operate as specialists in their own right. The particular instrumental features of Sub-Saharan African divinations, from one specialist to another, and one region to another, vary a great deal. But despite this diversity in the mechanics and instrumentality of divination, almost always the operator of the technique, the diviner, is considered to be divinely or spiritually inspired. The “technicality” of the divinatory instruments and the spirit source of the diagnostic opinion, outside of the person of the diviner, are supposed to give divination its authoritativeness. Sufferers and those who have experienced misfortune go to diviners to have several types of questions answered, according to French Africanist anthropologist Marc Augé. They want to know answers to “what” questions (what is going on?), to “why” questions (e.g., “why me, why us, why my family, why in relation to certain events?). Finally, they want “who” questions answered (is someone behind this misfortune, and if so, how do we deal with it?). Why these questions are of such interest in Africa calls for yet other kinds of inquiries.

The Search for Expertise in the Interpretation of Misfortune

Let us examine a number of examples of divination and then look at some issues in greater depth, before returning to that last question of why sufferers of sickness and misfortune in Sub-Saharan Africa want to have all these questions answered.

In the broad West Africa belt from Central Nigeria to Ghana, the prevailing mode of divination is known as Ifa. A cup bearing a set of usually 16 cowries or pods is thrown out into a tray. The combination of “ups” and “downs” is coded to indicate a set of verses, numbering in the thousands, which illuminate the life situation involved in the affair before the diviner. The tray or the cup usually bears the image of Eshu Elegba, the trickster, who is believed somehow to hold in his hands individuals’ and families’ fortunes. He is said to attempt ceaselessly to surprise humans with contradictory and unintended turns of events, often for the worse. Thus he and his character of trickery, deceit, and surprise embody the essence of what divination seeks to illuminate and to set straight, to clarify.⁶⁵

⁶⁵ Pemberton, in Pelton, 1980: 136.

On the Southern Savanna, from the Atlantic coast southeastward to the Copper Belt, the Ngombo basket mode of divination is common. [**Chokwe**] Its thorough integration into the societies suggests that the genre may be a thousand years old. Carved figurines and natural objects, representing human situations and predicaments, lie together in the basket. As the basket is shaken, one of the objects emerges at the basket's rim between two lumps of clay, one red, and the other white. This "gateway" of white and red suggests the liminality of the threshold between the visible and the invisible spirit world. The diviner reads the case before him in the light of the emergent object or the constellation of objects in the basket. ⁶⁶

In Southern Africa a common mode of divination is a bag of animal bones and perhaps seashells (brought or traded from coastal areas) which are shaken out and thrown onto a mat before the diviner and the client. [**Throwing the bones, I. Mabusa**] The bones, whose constellation represents issues in human life, relationships, and the world of spirits, may be combined with trances to indicate a complex hierarchy of causation behind the surface realities of a misfortune.

Bilumbu Divination in Kinshasa

In urban Kinshasa all the traditions of Western Equatorial Africa may be found in the back streets of vast districts of recent immigrants from the entire Congo Basin. Continuing regional wars and instability have uprooted and propelled flight to the city as families and lineages seek to put their lives back together. **Kishi Nzembula in Kinshasa** represents a Southern Savanna Luba family tradition, the "Makenga" variant, which means "to work for those who need it." Kishi Nzembula when I visited her in 1982 was a 65 year old woman, mother of eight, grandmother of 22. Her work was regarded by local scholars as within the Luba therapeutic tradition, although unique or distinctive in that she managed the spirit of her own deceased daughter in this tradition that stemmed patrilineally, in classic Luba agnatic manner, from her father and her paternal grandfather. It was as if urbanization had caused a feminized inversion of the deep patrilineal genealogy of spiritual transmission.

Nzembula entered her work eight years earlier, in 1948, when her daughter Janet, then 19, a very dynamic person, had been elected to head a group of handicapped children, she being a cripple. She died in pregnancy, for no apparent reason anyone could discern. The doctors tried to rescue the baby in a post-mortem surgery, but that was in vain. There were two burials that day. Janet's photo appears in a number of places in the house and in a prominent place in the chapel.

Eight years later, in 1956, her brother, a soldier at the time in Paris, was possessed by the spirit of Janet following a sickness that he could not overcome with the help of hospitals. He began dreaming of her. She instructed the family to give her a proper burial, to construct a beautiful tomb. They did as instructed, held a big feast, and played the ngoma drum for the *byombela* rite. Having done this, Nzembula's mother appeared to her in a dream and told her that there was no conflict between the work of Janet—possession healing—and being a Catholic. Thus, she continued attending church regularly, and told the priests of her dilemma. She persuaded them to not judge her, and she continued her work as a faithful Christian and a medium.

She has continued working with many clients, both within the family outside, including a few Europeans. Her family at first opposed her taking up this work, but when the spirits persisted, they consented. As if to confirm the validity of her practice, a European client came to consult her over

⁶⁶ V.W. Turner, *Revelation and Divination*. 1975, pp. 315-316.

business and family concerns. During the divining and therapy the family's teenage girl went into trance and revealed that her ancestors had been against the marriage to a man of another background.

Nzembela prays and worships on Sunday, and conducts no divinations or therapies. Other days she is very busy, at least in the mornings. Some clients enter into trance quickly, others need white powder sprinkled on them to make it. She offered that her own behavior may affect the degree to which Janet will possess clients. Sometimes Janet journeys to Europe to visit her siblings, in which case she won't respond to singing and chanting in the séances. Most of Nzembela's clients are Luba, but there are many others.

A session will typically begin with an assistant, a client in therapy long-term, beginning the singing with the help of a ten rattle. Other clients are seated on the floor around the main chapel. Presently Janet will come to the assistant, at first greeting her "mama," then speaking through the medium to the client usually in an accusatory tone, identifying the source of the problem and what must be done about it. Nzembela then intervenes and may ask Janet some further questions, and offering advice the client. Perhaps she may invoke a prohibition or a prescription, or give the client white powder or other medication and counseling. The structure of the session is the following. Singing and rhythm led by Nzembela, possession by a client or patient; divination by assistant in trance, reporting on others "through Janet" to Nzembela; Nzembela's therapy and counsel.

Neo-Christian Kongo Divination: Marie Kukunda

The diviner I know best, in the sense that I have seen her work in a number of cases, is **Mama Marie Kukunda in the north Manianga** region near the border between the two Congos. Like many effective healers and diviners, she traced her gift of clairvoyance to a near-death sickness when a young woman. In the strongly Protestant region of the North Manianga evangelized by the Swedish Covenant Church, Mama Marie was a deaconess in good standing in the local Protestant church, and knew her Bible well. In fact, this bible which she kept on the stool beside her in her divination chapel, was her instrument of divination. Frequently she would leave through its worn pages pensively when dealing with a case, and then allow the pages to drop open at a verse that gave her the "reading" of the case. An old man with a dream about a forest, on reviewing scripture, was comforted with the announcement that it was nothing to be troubled about. An anxious mother with a snotty-nosed infant, was told with or without Bible consultation that there "was nothing else going on." However, a wayward husband of two young children was warned by Marie, in the presence of his young wife, to take his responsibility seriously and stop philandering. For all intents and purposes, Kukunda's Bible divination followed the tradition of the Ngombo basket that had existed very widely in Lower Congo until the prophet movements of the 1920s.

Marie was at her best, however, with big lineage or inter-lineage conflicts. She knew how to stage big meetings to "inspect kinship" and inter-clan relationships so as to get to the bottom of sickness-causing prolonged conflicts. Several of these are reviewed in the next chapter.⁶⁷

These and many other types of divination in Sub-Saharan Africa are predicated on the assumption that sickness or other misfortunes may be caused by an untoward turn of events in the human or related

⁶⁷ See Figures 5.1-3 in the next lecture/chapter.

spirit world. The immediate cause or agent such as the sign or symptom of disease is thought to require interpretation in the light of ultimate natural, human or spirit agents. Thus, despite widespread acceptance of modern science, divination continues to be a common method for discerning the dividing line between that which “just happens” and the human or mystical factor that is seen as important in the pattern of misfortune.

Differentiating what “just happens” from “agency-caused” misfortune

As important as practical medicines is the pervasive concern that Kongo therapy managers spoke of as “something else going on.”⁶⁸ There is a shift from pragmatic to ritualized therapy that occurs because the misfortune or affliction is perceived to be fraught with anxiety and fear of pollution by both human and superhuman conflict.⁶⁹ This shift amounts to a purposeful amplification in practical care with affective symbols referring to the human dimension, to spirits, and to efforts to manipulate them. Usually only consecrated persons are considered capable of handling such powerful therapies as the purification of polluted persons and settings, making sacrifices to ancestors or neutralizing menacing spirits.

The pervasiveness of divination in treating African sickness and misfortune attests to the importance of causation, especially the suspected shift in cause from a mundane to a highly charged cause in the human or spirit realm. Usually consultation with a diviner is not undertaken until there is sufficient reason in the kin group of the sufferer to suspect causes other than natural ones. Such a precipitating factor may be the worsening turn of a sick person, a sudden and mysterious death, the coincidence of a sickness with a conflict in the close social environment of the sufferer, or the paradoxical occurrence of a disease on only one side of a family. In such cases the clients are looking for answers to questions not only of “**Why did it happen?**” but “**Why did it happen to us?**” and possibly “**Who caused it?**” and “**What should we do about it?**”

[Mama Marie Kukunda, and the case of Buyala conflict]

Scientific explanations of health may not necessarily lay to rest these questions, which are of a different order from the ideas in natural causation. A community may know very well that the spirochete transmitted by the bite of an anopheles mosquito causes malaria in the blood of a human. But the diviner may shed light on the question of why some people are infected and not others, or why some died when all were infected. Divination may also clarify the human causes behind accidents or provide a pattern with which to explain them. Western medicine is often good at answering “why?” but not “why me?”

[Conflict and striking twin are the two causes of the cancer of the Buyala man, according to Kukunda]

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Science or Magic?

Anthropologists, philosophers, and other scholars have debated the nature of African medicine and thought ever since David Livingstone published his debate with an Mbundu rain maker,⁷⁰ designed to

⁶⁸ J.M. Janzen, *Quest for Therapy in Lower Zaire*. 1978.

⁶⁹ G. Prins, 1981.

⁷⁰ J.M. Janzen, *Quest for Therapy in Lower Zaire*. (California, 1978), pp. 38-40.

show that the latter, although rational, was arguing with false premises. All participants in the anthropological debates accept empirically effective medicines, as mentioned earlier. The debate focuses on the nature of the other logic—the human or the spirit logic—and the relationship between these and the empirical or “natural” realm of causes and cures. The anthropological arguments range along a spectrum from prioritizing the empirical treatments to charging that witchcraft overrules other causalities in African medical thought. A range of terms has been put forward to identify the several logics that work together in African healing thought, as for example naturalistic, personalistic, God-caused, or human-caused.

Many scholars of African medicine today would not be likely to use Foster’s global distinction between “personalistic” and “naturalistic” treatments, because it just does not fit well. Illnesses that “just happen”—we would say naturally—are attributed to God, a personalistic force. Nor would this dichotomy very readily do justice to impersonal ideas of pollution brought about by exposure to the dead, to certain diseases, and brushing one’s feet against polluting substances. Similarly, few would accept Murdock’s global survey of theories of illness, in which African societies, based on the survey’s reading of available ethnographies, demonstrated a prevalence of supernatural (including fate, ominous sensations, contagion, mystical retribution, soul loss, spirit aggression, sorcery, and witchcraft) over natural (including infection, stress, deterioration, and accident) etiologies.⁷¹ Nevertheless, British anthropologist Robert Pool, who has studied Cameroonian societies,⁷² has joined Murdock and scholars of other disciplines, missionaries, travelers, government administrators (pre- and post-colonial, foreign and African), doctors and health officials, and economic development professionals, who have taken these simplistic dichotomies and characterized African health beliefs as operating primarily in the domain of “personalistic” or “supernatural” shaped witchcraft, sorcery and/or spirits.

These authors misrepresent E.E. Evans-Pritchard’s classic on Azande attribution of collapsing granaries and other misfortunes to witchcraft⁷³ to endorse their views. A careful reading of Evans-Pritchard reveals that he describes a “hierarchy of resorts ranging from simple to serious, with recourse first to empirical treatments, then to magical interventions”.⁷⁴ Yet many scholars of African healing and religion, who have experienced attributions to witchcraft for events Westerners would say were caused by gravity, germs, or sheer coincidence, prioritize this explanation over one in which events merely occur because they occur.⁷⁵

A third group of scholars began to find evidence of empiricism and rational, logical thought in African ethnomedicine.⁷⁶ Horton in particular sought parallels between African and Western thought, including in the domain of health and illness. Anthropological opinion has changed considerably since the 1970s, in part because of the involvement of anthropologists in applied research of infectious diseases such as

⁷¹ G.P. Murdock, *Theories of Illness*. 1980, p. 48.

⁷² R. Pool, “On the creation and dissolution of ethnomedical systems in the medical ethnography of Africa,” *Africa* 64 (1994), 1.

⁷³ E.E. Evans-Pritchard, *Witchcraft, Oracles and Magic among the Azande*. (Oxford, 1937), p. 67.

⁷⁴ J.M. Janzen, “The need for a taxonomy of health in the study of African therapeutics.” *Social Science & Medicine*, 15B (1981), pp. 188-9.

⁷⁵ For example see Turner on the Ndembu, in *The Forest of Symbols*. (Cornell, 1967), pp. 300-301.

⁷⁶ Robin Horton, “African traditional thought and Western science.” *Africa* 37 (1967), 50 & 155; M. Fortes, “Foreword,” In *Social Anthropology and Medicine*, J. Loudon, ed. London: Academic Press, 1976; P. Stanley Yoder, ed., *African Health and Healing Systems*. Crossroads, 1982; Brian Morris, “The powers of nature.” *Anthropology and Medicine* 5(1998), 1, 81-102.

child diarrhea and sexually transmitted diseases.⁷⁷ For example, recent research suggests that while magico-religious or supernatural ideas may often be associated with mental illness and certain other conditions, naturalistic etiologic notions rooted in empiricism are often found to underlie the infectious and contagious diseases that have always accounted for the greatest morbidity and mortality.⁷⁸ Diseases such as malaria, tuberculosis, schistosomiasis, cholera, amoebic dysentery, AIDS and other sexually transmitted diseases, typhoid, acute respiratory infections including pneumonia, yellow fever, leprosy and dengue tend to be understood within a framework that may be called indigenous contagion theory. In this analytic framework, one becomes ill because of impersonal exposure. One comes into contact with something that anyone could come into contact with, not because an avenging spirit or an ill-intended person singles one out for misfortune in the form of sickness.

A fourth group of scholars has sought to formulate the relationship between disparate types of logic and misfortune causation in African thought in terms of the importance of contextual social circumstances that determine their alternative or combined use. Morris, for example, notes that Chewa medicine includes an “empirical herbalist tradition, based on a belief in the intrinsic efficacy of certain plant and animal substances.” Yet it also includes “a cosmological tradition, which sees the human subject as a microcosm of the world and in which health was seen as restoring a balance or mix between certain vital ‘humors’ or principles, and a tradition that focused on ‘communal rites of affliction’, and involved spirit healing.”⁷⁹ How do these multiple realms of African healing relate to each other?

The late Rwandan scholar and physician Pierre-Claver Rwangabo offers an insight into contemporary African thinking on the question. Even though not all aspects of the Rwandan medicine system are amenable to modern science, Rwangabo believes that it is a part of modern reality rather than a fossil. He divides the causal domains of Rwandan medicine into “physical” and “mystical” causes. Diseases range across a variety of types which may be attributed to either causal category or to both. Rwangabo’s medical training is evident in his listing of disease classes that include: parasitic diseases, microbial diseases, systemic diseases and bodily accidents, gynecological and obstetrical diseases, and psycho-mental and behavioral diseases. But under the latter group he identifies current psychopathologies that entail abnormal behavior as understood in traditional thought and diseases believed to be caused by broken prohibitions and beliefs about ancestors (*abazimu*) and other spirits (*ibitega, amahembe, nyabingi, amashitani, amajini*) which often are identified in relation to mental illnesses. “Poisoning”, the result of human aggression, is a major aspect of the human source of misfortune. Misfortunes brought on by the breach of social rules also have a mystical though not necessarily mysterious causal character. Rwangabo’s insight into the character of traditional medicine lies in the observation that most pathologies may have both a physical and a mystical dimension. This affects the way therapy will be arranged. The decision to seek physical or other therapy has to do with the context in which it occurs, its severity, the suspected human etiology, and response to treatment.

This emphasis on the context of the causal attribution makes all the difference in how sufferers, their therapy managers, diviners, healers and medical practitioners will treat illness. If the misfortune is considered to be ordinary and predictable, it will be seen along the lines of the material world. If catastrophic forces or circumstances have precipitated it, or if it seems to be the result of the chaos of underlying affairs in the human and mystical realm, it must be handled differently. Thus the same

⁷⁷ Marcia Inhorn and Peter Brown, “The anthropology of infectious disease.” *Annual Review of Anthropology* 19 (1998), pp. 89-117; E.C. Green, *Indigenous Theories of Contagious Disease*. (Altamira, 1999).

⁷⁸ Green, 1999.

⁷⁹ Morris, 1998, p. 86.

condition may need to be treated with different medicines. The first realm we might term “natural”, the second “unnatural”. But this dichotomy requires closer examination so as not simply to read into it influences of Western thinking.

In widespread sub-Saharan African parlance in the 20th century, the natural realm is associated with God, or caused by God—the God of the created universe,⁸⁰ not of a mechanistic Enlightenment nor of puritanical retribution for human sin. Rather, God-caused misfortune is widely seen to be the created order of things such as the seasons and rhythms of birth and death in society and in the surrounding world. The death of an elderly person would be “in the created order”, whereas the death of a child-bearing mother, for example, would be seen as “unnatural”, or caused by some other human or spirit force. The unnatural source of misfortune—which may be manifested in an otherwise scientifically understood disease—may be attributed to human error or malicious motive, arising from the many contradictions inherent in human society, or the deceptive, anti-social nature of some individuals. This view of humanity often includes the ancestors or spirits who have a vested interest in the outcome of human affairs, especially in their clans and localities.

Conclusion

We may revisit our earlier question of why the questions are asked—what, why, who. . . In any event, wherever scholars and clinicians have worked in Sub-Saharan Africa, they encounter divination and divination specialists. the wider understanding of the individual person to include these relationships—to kin, to ancestors, to spirits, to the earth. The individual in relation to the social group, and other individuals. the importance of understanding divination and its contextualizing questions in the greater project of improving health, of dealing with some of the health crises in the African continent. In my first lectures I have suggested why this might be the case: the possibility of relationships intervening in the occurrence of sickness;

The full implications of African divination may be studied in ethnographies of divination clinics, divination-type discussions in therapy management settings.⁸¹ Focus on the static vs. dynamic perspective highlighted in the previous lecture/seminar, and how it’s important to see the reasons for the shifting ground, Prins’ shift to high density etiology. Case examples: Luzayadio in *Quest*; the case studies on ebola outbreaks in Kikwit, Congo and Mbomo, Congo Brazzaville.

⁸⁰ V.W. Turner, *The Ritual Process* (Aldine, 1969), p. 52; J. Orley, “African medical taxonomy: with special reference to mental illness,” *J. Of the Anthro. Society of Oxford* 1(1970), pp. 137-150: 137; Marja-Liisa Swantz, *Ritual and Symbol in Transitional Zaramo Society*. (Gleerup, 1970); Harriet Ngubane, *Body and Mind in Zulu Medicine*. (Academic Press, 1977), pp. 22-24; Eva Gilles, “Causal criteria in African classifications of diseases,” In *Social Anthropology and Medicine*, Loudon, ed., pp. 358-369; Janzen, *Quest*, 1978: 44-49; Christopher Davis, *Death in Abeyance: Illness and Therapy among the Tabwa of Central Africa*. (Edinburgh, 2000), pp. 94-5.

⁸¹ Janzen & Green in H. Selain (2002/3); Susan Reynolds White; Ngudiankama among Kongolese in London.

ETIOLOGICAL DUALISM IN EBOLA PUBLIC HEALTH CRISES IN CENTRAL AFRICA ⁸²**Introduction**

Ætiological dualism@ is a recent phrase that has emerged to describe the widespread and historically deep articulation of and relationship between of two kinds of causal attributions of misfortune in Central African societies. In the first, sickness or misfortune is attributed to matter-of-fact notions of disease causation that are amenable to a variety of treatments, usually including biomedicine.⁸³ In the second, misfortune is attributed to hidden, malefic, aggressive, instincts and motives of a human or spirit agent. As widespread ethnographies have shown, single cases of affliction often shift from one type of cause to the other. Scholars have commonly interpreted this etiological dualism, and shifts, within the confines of traditional sickness perception, consulting a diviner and seeking ritual healing. This is also where the widespread literature on witchcraft and sorcery has been focused. In Western Bantu language expression, terms such as *kia Nzambi* (Æof God,@ the world as it is created) are used to describe the first type of etiology; *kia Muuntu* (Æof human@, of persons) characterizes the second. There are many and varied euphemisms for this dichotomy across the wider region.

Recently, however, depictions of etiological dualism have surfaced in accounts by journalists, medical workers, and scholars of outbreaks of epidemics. In cholera and Ebola outbreaks and escalating deaths by HIV/AIDS, not only lay therapy managers and diviners, but also living victims, survivors and their next of kin, local health workers, national health officials, NGO representatives, even anthropologists, find themselves in situations where accusations are leveled and assaults occur against alleged perpetrators of disease. Sometimes the very people trying to help with the emergency are accused of causing it.

Because of the limited time frame for conference papers and follow-up discussion, I will restrict myself here to accounts of hemorrhagic fever Ebola outbreaks, in particular those on which we have the best documentation. I will then offer a more comprehensive theoretical interpretation of etiological dualism and causal shifting that pays closer attention to the parameters of power, social control, risk and blame, within local social networks, institutions and understandings of personhood. The implications and lessons of this exercise are relevant to public health policies and strategies across Central Africa.

Documenting Ebola outbreaks

There is a wealth of good documentation on the natural history and public health of Ebola outbreaks in Central Africa. We know how many individuals were infected in each

⁸² First prepared for the Panel ÆEthnographic Turns and Cognitive Dissonance: Exploring Science, Magic, Healing, and Race,@ African Studies Association. Chair: Helen Tilley, Discussant: Megan Vaughn Friday November 18, 2005

⁸³ Allusion to such a "naturalistic" etiology across Central Africa is widespread in the ethnographic literature. See V.W. Turner, *The Ritual Process* (Aldine, 1969), p. 52; J. Orley, ÆAfrican medical taxonomy: with special reference to mental illness,@*J. Of the Anthro. Society of Oxford* 1(1970), pp. 137-150: 137; Marja-Liisa Swantz, *Ritual and Symbol in Transitional Zaramo Society*. (Gleerup, 1970); Harriet Ngubane, *Body and Mind in Zulu Medicine*. (Academic Press, 1977), pp. 22-24; Eva Gilles, ÆCausal criteria in African classifications of diseases,@In *Social Anthropology and Medicine*, Loudon, ed., pp. 358-369; Janzen, *Quest*, 1978: 44-49; Christopher Davis, *Death in Abeyance: Illness and Therapy among the Tabwa of Central Africa*. (Edinburgh, 2000), pp. 94-5.

epidemic, how many died, the vector suspected (almost always eating bush meat from primates), and the course of spread of the epidemic and how it was eventually contained or on its own came to a close.⁸⁴ Here are the highlights of that documentation on Central Africa from Formenty, Roth, and Grein (2004) before a WHO/Pasteur Institute colloquium held to gain strategies on dealing with Ebola.⁸⁵

- Cote d'Ivoire: 1994, 1 fatality;
- Gabon: 1994 (52 infected), 1996 (37 infected), 1996 (61 infected), 2001-02 (65 infected);
- Congo (Brazzaville): 2001-2 (57), 2002 (13), 2003-4 (Mbomo & Kelle, 143 cases/ 128 deaths) (35),
- Democratic Republic of Congo: 1976 (Yambuku, 318 cases, 280 deaths), 1977 (1), 1995 (Kikwit, 315 cases / 245 deaths),
- Uganda 2000 (425 infected),
- Sudan 1976 (284 cases, 154 deaths), 1977 (34), 2004 (Yambio, South Sudan, 17 cases/ 7 deaths).

This list of Ebola epidemics in recorded public health history is certainly not exhaustive; they only give some impression of the size, frequency, and distribution of the virus. Ebola is one type of virus in an entire class of hemorrhagic fevers that have been known worldwide. Its incubancy period is about five to ten days, and once infected, an individual experiences severe fever, cramps, and internal bleeding, and within a few days will either die or begin recovering. The mortality rate is from 60-90%. It has also become quite clear that most or all of these particular Central African epidemics were caused by individuals encountering infected primates. In most cases these have been hunters, or those who eat infected bush meat, or in the case of the Kikwit epidemic, a charcoal worker who probably was exposed in the forest where he collected and processed charcoal. Subsequent exposure is often to family members, to health workers who come in contact with the body, blood, or bodily fluids of the infected, or other hospital and clinic patients touched by the caregivers or fellow patients. Almost all of the Central African Ebola epidemics have endangered health care workers. In most epidemics nurses and doctors have been infected and died. WHO, CDC, and national health agencies have developed measures to protect health care workers. These involve rigorous disinfecting of surroundings where Ebola sufferers have been, careful disposal of clothing and material possessions of the infected, and, most challenging of all, the disposal of the bodies of the Ebola dead so as to meet cultural expectations of

⁸⁴ See for example the excellent website by Tara Waterman. *Tara=s Ebola Site*. Stanford University Honors Thesis. 1999. <http://www.stanford.edu/group/virus/filo/refs.html>

⁸⁵ Institut Pasteur. *Les epidemies de fièvre hemorragique a virus ebola en Afrique Centrale (2001-2003). Quelles strategies adopter pour controller les futures flambees? Atelier sur les fevres hemorragiques virales*. Institut Pasteur (amphithéâtre Duclaux), Paris, France. 7-8 septembre 2004.

<http://www.pathexo.fr/pages/Ebola/program.html>

Pierre Formenty, Cathy Roth, Thomas Grein. OMS, Département ARO, Genève, Suisse *Leçons apprises lors des dernières épidémies d'Ebola en Afrique* 2004

<http://www.pathexo.fr/pages/Ebola/Formenty.htm>

appropriate burial, while at the same time protecting the grieving and next of kin from further infection. Numerous films exist of these public health efforts at resolving Ebola crises.

The documentation and analysis of the sociocultural dimension of Ebola epidemics in Central Africa is far less thorough than the physical and public health dimensions. What exactly was the popular perception and reaction to the outbreak of this deadly disease? Who did what to whom? Who became a suspected agent of the grave danger to the community in the course of the epidemic? Who controlled or sought to steer the diagnosis and negotiated understanding of the misfortune? There are hints of such behaviors in the above reports. The WHO /CNRS report above suggest that the epidemics have usually come to an end because the populace of the afflicted region or communities simply flee from fear and thus no further contagion is possible. Others report that it has been most difficult to carry out public health measures of quarantine or disposal of diseased bodies because of customs that emphasize caring for the sick and dying, and bathing the dead before burial and grieving while holding them. Some reports emphasize the panic and fear of illiterate peasants and the difficulty of teaching them anything.

Journalistic accounts of Ebola outbreaks have often been sensationalist, which is not surprising given the high and fearsome death rates of infection (50 to 90%). The outbreaks in Congo-Brazzaville in 2003-4 were the best reported and best covered by both journalists and medical and anthropological teams. Here is a follow-up account by *Agence France Press* of this epidemic which claimed 128 lives over a several month period in a number of village communities in this region at the border of Congo-Brazzaville and Gabon. The headline conveys the dominant sentiment of the populace. AOne year later, the village of Mbomo still lives in fear of Ebola.⁸⁶

One year after an epidemic that causes the death of 35 persons, the mention of Ebola provokes a long silence and fright among the inhabitants of Mbomo, a small community situated at the border of Congo and Gabon.

At first view, the lessons taught by the authorities of Brazzaville, the Red Cross, or Doctors without Borders, about the epidemic of hemorrhagic fever that hit the region at the close of 2003, have been solidly learned. We no longer eat monkey, we no longer collect dead meat,"-- vectors of the virus-- the villagers assure the inquirer in a single chorus.

But, in the course of further conversation, doubts quickly reappear. "Ebola, is it a virus or sorcery?" asks Anne-Marie, mother of five children. "Many researchers have come and in the end they said it wasn't Ebola," follows her friend Alphonse.

⁸⁶ Un an après, le village de Mbomo vit toujours dans la crainte d'Ebola. CONGO (BRAZZA) - 16 décembre 2004 - AFP

http://www.lintelligent.com/gabarits/articleAFP_online.asp?art_cle=AFP43304unanaalobed0

Despite the education campaigns, beliefs hold firm regarding this virus that was first reported in Zaire in 1976. "The people say that it's sorcery because those that touched the bodies still are alive," says Celine, a hairdresser of 25. The witch hunt continues. Last year four teachers were accused of "mystical practices" and were lynched by the populace of Akele, a village neighboring on Mbomo.

. Others such as Armand accuse politicians of practicing human sacrifice "to have more power," or even the white people at the National Park of Odzala-Kokoua. In this district of more than 6,500 inhabitants, entire villages were abandoned out of fear of sorcery. Here and there, gravestones remind of three waves of the epidemic that from late 2001 to early 2004 hit the region and left around 300 dead.

Just a year ago, the schools and churches of Mbomo closed their doors, and the inhabitants remained cloistered in their houses and did not dare shake hands with their neighbors for fear of being contaminated.

. "During the epidemic, it was most difficult." Catherine Atsangandoko, head of the local medical center, recalls. "The people did not want to listen to instructions, they did not want to be told about Ebola, so they fled into the forest, or to their kinsmen."

Since 2003, one of the buildings named "Ebola" remains abandoned. "It has been disinfected," emphasizes Atsangandoko, as all the houses of the sick, even if sometimes buildings needed to be burned to avoid all contamination.

Those who suffered from the fever and the diarrhea associated with the virus refused to be cared for at the hospital, arguing that the medicines were one of the vectors of the disease, for which the mortality rate was 80%.

Gilbert Ndomba is one of the rare survivors of the last epidemic outbreak which caused 35 deaths in a single year. "I lost my children and my wife and I thought I was also going to die," he testified. "It was God who saved me," he says today. Living from collecting and hunting, this man of 33, as the majority of inhabitants of this large village, lived "from the meat of the bush during the epidemic, because canned food was too expensive."

Still today, a minority continues to hunt monkey and to eat it, believing that Ebola "will not return."

The Anthropology of Ebola, So Far

Only a very few sociocultural scholars have been able to observe and explicate the context of community response in the Ebola outbreaks. The French anthropologist-physician team Alain Epelboin and Pierre Formenty were part of a larger public health group that responded to the 2003-4 Congo Brazzaville outbreaks. (Dr. Pierre Formenty is responsible in the WHO for research on the sociocultural background of hemorrhagic fever, and Professor Dr. Alain Epelboin is a medical anthropologist with CNRS-MNHN.⁸⁷) They have written brief

⁸⁷ Centre Nationale de Recherche Scientifique, roughly equivalent to the U.S. National Research Council, NSF, and in some areas, NIH.

reports⁸⁸ and circulated preliminary papers⁸⁹ of these events and have made a number of video films of their interventions and recommendations. Austrian medical anthropologist and physician Armin Prinz reported the 2004 Southern Sudan outbreak from across the DRC border and has prepared brief reports on that as well.⁹⁰

The Epelboin & Formenty report gives us a detailed account of two interlinked outbreaks that continue for months in Mbomo and Kelle, near the Gabon/Congo border. The medical team and researchers were not actually present for the onset when several local school teachers were accused of having caused the Ebola and were assaulted and killed, and people near the Ebola victims either fled into the forests or locked themselves into their houses. The accusation of Europeans at a nearby nature reserve is most interesting; they are charged with enriching themselves with local resources, thus, somehow, implicating them in the Ebola outbreak. This is not covered in the ethnographies. The research/medical team's involvement came as health experts arrived to try to introduce measures that would interrupt the transmission of the virus to new cases. Apparently in one instance rigorous quarantine measures were resisted when the affected people fled from health authorities or hid their diseased next of kin. In the other community where the anthropologist was on hand, there was a greater degree of collaboration. The difference may have been due to the anthropologist's encouragement of customary burials, including permission to put the draped corpses into coffins, and the personal possessions of the deceased on the graves, rather than to have the corpses and materials burned. These more "humane" treatments of the deceased were possible when the public health team donned protective clothing, used extensive disinfectant sprays on funeral participants, and created a barrier around the cemetery.

As they suggest, even with all the limitations of a little over one week of actual field presence, many good interviews and group meetings were held and a general picture emerged of how two communities in Mbomo and Kelle dealt with the actual outbreaks. Thus this quick primary ethnography offers material for an initial analysis, and the promise of better understanding next time such an outbreak occurs in these communities or elsewhere. The authors are to be congratulated on getting this material into print or onto the internet so quickly. The challenge is to put this material through critique and review so it may be subjected to the best public health and medical anthropology analytical perspectives. I will have more to say about the conceptual approach to the interpretation by Epelboin and Formenty later on, by way of encouraging them to situate their material in the tradition of Africanist medical anthropology on "etiological dualism."

⁸⁸ Alain Epelboin & Pierre Formenty. *Anthropologie appliquée en situation d'épidémie : Ebola au Congo en 2003*. <http://www.pathexo.fr/pages/Ebola/Epelboin.htm>

⁸⁹ Review of Manuscript Submitted to *Medical Anthropology*, Spring, 2004, J.M.Janzen.

⁹⁰ Research Proposal, Professor Armin Prinz, M.D., PhD, Head, Ethnomedicine Department, Institute of the History of Medicine, Medical University of Vienna, Fall, 2004. Literature references and preliminary writings can be ordered from armin.prinz@meduniwien.ac.at Translated from German by J.M.Janzen.

The second example of anthropological reporting on Ebola outbreaks is by Armin Prinz, who in 2004 was doing follow-up research among the Azande of northern DRC. The Yambio outbreak he reports is among Azande across the border in Sudan. In personal communications to the author, Prinz sketches his remarks within the broader framework of emphasizing the importance of ethnomedicine, the importance of traditional medicine to many societies, and the chaos that has affected traditional healing elites in this region of the Azande society.

In broad regions of Africa, as otherwise in developing societies, the population is largely dependant on traditional medicine for health care. In many regions Western medicine is non existent or rudimentary because of civil war and the impoverishment of the population. Still existing medical institutions in remote regions have to work under unbelievable conditions. This is true not just of Western medicine, but also of traditional systems, both of which have experienced far-reaching changes.

In recent years there have been massive disturbances of indigenous health care provisioning. In Northeast Congo for example due to the civil war and the fear of the reigning warlords of the magical powers of healers, hundreds of these specialists were murdered in a grisly manner. The mechanisms of the perceptions that caused this sudden loss of the people and its effects will be the basis of the proposed research.

Prinz here describes the wholesale massacre of traditional healers following the chaos of civil war, resultant disease outbreaks, and the fear of the magical power of healers. Not unrelated is the witchcraft accusations against those who appear to know something about AIDS or other epidemics. The dynamic at work here is hardly understood, yet it is crucial to effective intervention in epidemics.

Often the social upheaval and extraordinary burdens through diseases such as AIDS may lead to witchcraft accusations, for the accused, may end fatally. Perceptions of witchcraft and magic are real facts for the people, well grounded in daily experience and not part of a metaphysical order. These perceptions are idea-wise a part of the mechanisms of social control. However Western bio-sciences may understand these phenomena, for the people they are experiential and painful manifestations that should be examined and explained by ethnomedicine.

Closely related to this thematic arena belong the sociocultural and economic backgrounds of epidemics. This important research problem may be briefly sketched in the light of the most recent Ebola outbreak in Southern Sudan.

Prinz goes on to report on the disastrous effects of lack of ethnomedical understanding by of all NGO groups the prestigious Doctors without Borders.

Doctors without Borders initiated quarantine measures without adequate ethnomedical preparatory research. The "success" of the initiative resulted in the people beginning to hide their sick from the medical authorities.

Prinz, Epelboin and Formenty compared notes at the colloquium on Ebola hosted in September 2004 by the Institut Pasteur in Paris. These and other colloquy visitors agreed on the importance of "ethnomedical information for the health worker, in order to explain quarantine measures to the populace, so as to be able to modify the awareness of the people's consciousness of disease on which their intervention measures are based."

Contextual anthropological analysis of Ebola outbreaks and other emergencies

What is so far missing from these quick or emergent ethnographies of Ebola is any attempt to connect them to the extensive scholarship on Central and Equatorial African health and healing and medical pluralism, to the analysis of society and power. The analytical approach utilized by Epelboin and Formenty is the Explanatory Model and the integration of local knowledge into biomedical framework.⁹¹ They also emphasize the importance of sensitivity to local customs of care for the sick, dying, and the dead, as well as the role of healers in society, especially stressed by Armin Prinz.

Weak or missing in these reports is a good grasp of the social context of the negotiation of diagnosis of the emergency, and the social framework in which such diagnosis is controlled. Solely cultural and cognitive models fail to account for social dynamics and power; they do not connect the verbal and non-verbal categories, agents, and attributes of misfortune to the social and political context within which sufferers or their next of kin, or their health experts, seek to define and bring under control. Epelboin and Formenty tend to refer to the cultural characteristics of the ethnic groups of the region in which they work, as if there is cultural homogeneity and neighboring cultures are distinctive.

The literature on therapy management in Equatorial African societies reveals that this group of mostly kin, occasionally biomedical and other authorities, presides over the debate about causation, and with the help of diviners, prophet-seers, and biomedical establishments to come to resolution. In the present reports on Ebola a reader can follow the outlines of who is seeking to control or manage the diagnosis and steps of care. But there is no closely focused ethnography and analysis of this process in the various groups or patient kin groups, or in the months-long unfolding waves of epidemic outbreaks. It would be very helpful to provide this social information in a more organized way if it could be gleaned from observation or from retrospective accounts.

A cursory reading of some recent writings on the medical anthropology and history of Central and Equatorial Africa would reveal the recurring discovery and discussion of the etiological dualism that the authors also uncover: sorcery-related versus Anaturally@

⁹¹ The EM is Arthur Kleinman's early 1970s approach developed in Taiwan, and long since put in doubt by himself for being overly cognitive and apolitical, lacking in social context. The Asecond@ approach is not referenced either, but it is really the same as the first, with the inclusion of biomedicine into the explanatory model. The authors acknowledge their cultural perception bias and emphasize their assumption that perception is the basis for action (p. 10).

occurring misfortune. Just what this duality means and how and why it emerges in particular cases, and how it seems to fluctuate from one situation to the next, are not well understood or explained in the accounts. Indeed, it appears that there is significant difference in the categorization of Ebola in the two regions of outbreak and surveillance. Why? We aren't told. It would be helpful for the authors to situate their observation of this etiological dichotomy with reference to the literature on the subject.⁹² Many studies relate the etiological dichotomy not only to local knowledge or culture of illness and affliction, but emphasize that it reflects issues of organization, control, and power.

Current thinking amongst Africanist medical anthropologists who work in Equatorial and Central Africa is that social control is an absolutely critical factor in the etiological judgment of misfortune. Mary Douglas's work on the association of cosmologies (grid) to social authority and structure (group) suggested ways of identifying either degrees of chaos and of order, of control or lack of control.⁹³ Where social and political decentralization prevail, or issues of danger remain ambiguous, and no authorities "take charge" of the discourse of misfortune, there blame-seeking runs rampant. In the Central African setting, "sorcery" or "witchcraft" suspicions abound, although Douglas has long ago identified similar other-blaming behavior in Western industrialized society. The identification of at-risk categories of society is the same process, filtered through probability statistics and public health screening, of the allocation of danger. Where there is greater control or more hierarchical authority, there is a quicker willingness to allow for a natural illness attribution. It may also be that in these sketchy ethnographies of the empathetic physician-anthropologist, the outside expert engages in discussion and negotiation with the local therapy managers, and this new knowledge suffices to sway the consensus to the acceptance of a natural option and therefore one that allows for medical interventions --isolation, medication, and health education-- rather than need for prayer, sorcery hysteria, and the urge for revenge killing.

So, the question of the social context of attempted response to misfortune, the nature of the negotiation, who is involved, the institutionalized or de facto articulation of agency, are all very important in swaying the etiological attribution between sorcery or naturally occurring affliction. We are not looking at a dichotomy of scientific knowledge versus social knowledge, so much as a dichotomy in which matter-of-fact knowledge is overtaken, overwhelmed by, considerations of threat by an antagonistic agent bent on destruction and death. The implications for health officials and communities are obviously very great, and determine whether such officials or teams will be part of the solution, or whether they are perceived to be part of the problem. The successfully negotiated introduction of new public health knowledge required to deal effectively with Ebola required a successful negotiation of the social logic of local kin and political groupings and power constellations.

⁹² Anthropologists in the French tradition who have evaluated such situations include such as Nicole Sinzinger, Gilles Bibeau, and Marc Auge; in the English-American, John Janzen, Steven Feierman, Christopher Davis, Ellen Gilles, Gwynne Prins, Murray Last, Susan Reynolds Whyte, Renee Devisch, and others.

⁹³ First spelled out in *Natural Symbols*, but more recently and forcefully applied to risk assessment in *Risk and Blame* (1992)

Chapter 8

DUMUNA: THE POWER OF THE MARGINS & SUBALTERN AUTHORITY IN NORTH KONGO (or, HEALING SOCIAL CONTRADICTIONS)⁹⁴

North Kongo historic society reveals widespread sensitivity toward the power of marginal segments in the community: junior lineages, strangers, persons with mystical sensibilities, or the sick. This recognition of the marginal in society echoes contemporary 21st century preoccupations with human rights, the comparative study of healing, and the complexity of authority patterns. Of relevance to the ASA 2007 theme of human rights is the strong implication that colonial and postcolonial ignorance of this important structural feature of historic Kongo institutions and the imposition of singular hierarchies of authority have contributed to rights abuses and recourse to violence. The highlighting of sickness and healing in Western Equatorial African society seems extensive to the modern Western observer. Yet it is an idiom that occurs widely in historic Kongo communities as an expression of social issues relating to the composition of authority and the breakdown of authority. Sickness and healing of certain individuals become metaphors for the disorder and recreation of order in Kongo society. These metaphors are either projected onto individuals, or become the body/ person/ body/ society construct widely seen in many societies.

The social science literature on these historic structures in Kongo and more widely Western Equatorial Africa have commonly highlighted the distinctive customs and experiences of societies of the region. In this paper I use my own original ethnographical research to make the point that the customary patterns of authority are reflections of societal pressures in an environment of global economy of the mercantile trade (17th-18th centuries) and colonialism (19th-early 20th centuries) as much as they are unique inventions of insightful rulers. I will demonstrate this argument with three examples of the recognition of subaltern authority. The first case shows the constitution of such an office "from below" early in the colonial period alongside the colonial chiefship. The second case reflects the abandoned structure of subaltern authority reconstituted by a charismatic prophet-pastor within a mission church framework. The third case shows the principle at work in the emergence of a Christian independent church within a postcolonial community that did not previously institutionalize subaltern authority. All are from the North Manianga region of the wider Kikongo speaking region.

The making and unmaking of authority in Kongo political history

The most widespread Western Bantu political institution that has endured for centuries is the *nsi*, the local domain.⁹⁵ In Kongo society, the *nsi* usually was organized through at

⁹⁴ This chapter is based on the 2004 lecture and a 2007 presentation at the African Studies Association, New York, October 20, 2007, in the panel "Voices from the Margins: Constructing Power and Authority."

⁹⁵ Vansina has described the historic origin of the *nsi*, in his *Tio Kingdom of Middle Congo 1880-1892* (London: Oxford, 1973), pp 313 ff. and in his *Paths in the Rainforests* (Madison: U. of Wisconsin Press,

least two allied but exogamous matrilineal descent communities. The clan (*luvila*) was a category of descent from a putatively common ancestor, the geneologies and migratory stories used to recall this ancestry being of a mythological character. In the region of the old Kongo kingdom, narratives of clans such as Mpanzu, Kinsaku, Nsundi, Bwende, Kingoyi, and Mazinga invariably lead back to ancestry from the capital of the kingdom, and migration to the present locale. The local lineage, *dikanda*, consists of locally related individuals with common descent from individually-identified ancestors. Adoptions, replacements of kin groups without issue, and outright takeovers by subordinates are known, so that it is clear that we are dealing here with an ideology of consanguinity as the basis of political formation. An essential dimension in the political backdrop of Kongo society of coastal Zaire, Congo and Angola is the presence of centralized kingdoms over wide expanses of this territory since the 13th century: the large Kongo kingdom founded ca. 1200 at its capital in northern Angola, and a series of smaller, older, and as durable kingdoms such as Nsundi, Loango, Ngoyo, Kakongo; and many smaller scattered chiefdoms.

The political culture of the Kongo region generated a set of similar institutions--titles, structures--derived from these Kongo states. For example, In the Kongo kingdom the sacerdotal authority was vested in the autochthonous Nsaku ne Vunda clan whose ancestors were associated with the earth; the monarchy was held by a conquering clan. This complementarity was mirrored in many later local arrangements. In Loango governors rotated of the four provinces in a particular order before acceding to the kingship. In other coastal kingdoms, the office of the priest of the earth, who inaugurated the king, held authority separate from the kingship.

Other sociopolitical arrangements complemented these arrangements, including local clan and village organizations, market systems either locally organized around the four-day market week, or as part of long-distance trading networks, ultimately connecting with the coastal international trade handled since the 15th century by Portuguese, Dutch, British, French and other merchants. There were shrine and cult hierarchies and networks, either related to local landed estates or to functional specialties around misfortune--e.g., reproductive disorders, clan reproduction.

By the 17th century the centralized polities that had existed earlier were destroyed and replaced by mercantile networks, which were in turn ceremonialized through such cult orders as Lemba.⁹⁶ The north Manianga region never was brought into the centralized tribute, title or authority sphere of any of the area's kingdoms or chiefdoms, so it was essentially an acephalous society at the beginning of, and in many ways during, the rule of the Congo Free State beginning in 1870s. The mode of political action and judicial intervention tended to be that of a council rather than the office of a political leader and his court. Congo Free State agents, and after 1908 the agents of the Belgian Congo, had considerable trouble dealing with these councils, which they considered to be a kind of anarchy. They sought repeatedly to impose, or to tease into being, what they considered

1990), pp. 81-83, 274; see also Janzen, *Lemba*, 1982: 44; and MacGaffey, *Custom and Government in Lower Congo* (Berkeley: University of California Press, 1970), pp. 202-203.

⁹⁶ Janzen, J.M., *Lemba 1650-1930: A Drum of Affliction in Africa and the New World*. (New York: Garland Publishers, 1982).

proper centralized chiefship, in an effort to emulate British "indirect rule." From the 1870s and 1880s on, labor recruitment for the construction of railroads from the coast inward, for plantation work, as well as taxation had begun in Lower Congo. This new external authority was perceived to be not only ruthless, but arbitrary. Often agents inaugurated whoever they could find for their needs, rather than current leaders who tended to avoid colonial agents. This not only eroded local councillor authority, but created a system of imposed puppet authorities known as *chefs medaillees*, after the medallions they received from the colonial state. In 1921, after Belgian colonial authority became as systematic as it was ruthless, the well-known millenarian movement known as *ngunzisme* erupted, around the prophet Simon Kimbangu and his followers. Against the backdrop of intensive Baptist and Swedish Covenant Church missionization, Kimbangu advocated support for missions and government, renewal of ties to the ancestors as well as Christianity, and a systematic destruction of all ineffectual consecrated medicines, *minkisi*.

The most common and widespread office to combine principles of wider authority with the *nsi* landed domain was the *kimfumu mpu*,⁹⁷ the chiefship of the hat or bonnet, sometimes also called the *kimfumu nsi*. Records from the northern reaches of the Nsundi kingdom (the northern province of the Kongo kingdom) indicate this form of authority was formalized in the kingdom structure, whereas beyond the boundaries of the kingdom, the *kimfumu mpu* was constituted "from below" by kinsmen, affines, and loose political allies. The *mpu*'s ideology of consanguinity with a sense of place tied to land generally focused on the claim to a legitimate cemetery, an *nsi* domain, was the basis of the claim also to the right to own an *mpu* or crowned chiefship (*mpu* = hat, crown). In practice, the chiefship tended to be identified with a local clan section, that is with one cemetery, at that point in its genealogical reckoning where several--often three--local lineages of the same clan came together.

Following the diagnosis by a diviner of misfortune in the clan, or that the individual was afflicted, and that his only hope of health lay in his investiture to the *mpu* chiefship.⁹⁸ Sickness is here defined to include both the physical symptoms and signs of the afflicted, as well as the social and political chaos that is suspected to have caused it; healing is then the creation of authoritative rule or consensus, as well as the consequent disappearance of the symptoms and signs of sickness.

⁹⁷ Sources on the *mpu* include: my own fieldwork in 1965 and 1969, and colonial archives in Luozi, in particular a detailed report an investiture by territorial agent E.O. Vercraeye; published sources are: for the Mayombe region, J. Mertens, *Les chefs couronnés chez les BaKongo Orientaux*, (Bruxelles: Institut Royal Colonial Belge, 1942), and Albert Doutreloux, *L'ombre des fétiches: Société et Culture Yombe*, (Louvain: Editions Nauwelaerts, 1967); for the Mpangu region south of the Congo river, J. Van Wing, *Etudes BaKongo* (Bruxelles: Desclée de Brouwer, 1959), especially chapter IV, "L'autorité et le Culte"; sources drawn from the Manianga region include Wyatt MacGaffey, *Kongo Political Culture* (Bloomington: Indiana U. Press, 2000), and Kimpianga Mahaniah, *La Maladie et la Guérison en Milieu Kongo* (Luozi: EDICVA, 1982), particularly his chapter on Les fonctions thérapeutiques de l'autorité des Kongo a travers des siŋcles, p. 175 ff; Luc de Heusch, *Le roi de Kongo et les monstres sacrés* (Paris: Gallimard, 2000), and John Thornton, writing on the *kitomi* system in the heartland of the Kongo kingdom, in *The Kingdom of Kongo... 1641-1718* (Madison: U. of Wisconsin Press, 1983).

⁹⁸ Mertens, J., *Les chefs couronnés chez les BaKongo Orientaux*. (Bruxelles: Institut Royal Colonial Belge, 1942), p. 48; MacGaffey Custom, 1970: 235-6.

Informants where the second type of investiture--from below--prevailed, told me that the mpu holder was "elected", *tumbwa*, through ancestral call, and was thereafter consecrated and initiated,⁹⁹ and that the ecstatic trembling associated with modern Kongo prophets was commonplace earlier on the part of the mpu crowned chiefs, as a sign of the indwelling of ancestral power.¹⁰⁰ Structurally, the mpu was held in a free clan with clear title or claim to a permanent clan cemetery. But it was often held in the junior house (belo) of the clan

Kingoyi of Kimata: Legitimizing Authority in the Face of Colonial Chiefship (1933)

The Kingoyi clan, dominant in a region north of the Congo river in the Manianga or Luozi Zone of the Lower Congo, was one of the clans that had received the mpu from the ntotila king of Nsundi, once a province of the Kongo kingdom. By the twentieth century, the ultimate mpu giver clan, Nsaku na Vunda, auchtonons of the Kongo capital in the 13th century, were represented in two sections in the Manianga region. Evidence of their clan and place name, Kinsaku of Kivunda, suggested that they had been part of the vanguard of the 18th century Kongo migration across the river. In typical conquest voice, their origin narrative told of how the first man, Mwene Vunda, had come from the Kongo capital, Kongo dia Ntotila, to Kivunda Muyenze, with his sisters Makulu Makaku, Makulu Masengele, and Bubu, of the land at Kivunda. According to the local narrative, Kinsaku and Mpanga were the only free clans; Kingoyi and the other clans were their slaves.¹⁰¹ But Kingoyi was present in all villages, thus the most populous, (see table).¹⁰² Kingoyi's narrative was that they, together with the Kimpanga, also originated from Kongo dia Ntotila, the capital, then Kongo dia Gungu. The land was empty when they arrived. They claimed affiliation with another Kingoyi clan of south of the river; they dispersed at Zimba¹⁰³ near Kimbanza, one of the subcapitals of Nsundi.

village	clan	Kingoyi	Kikwimba	Kimpanga	Kindamba	Kinkumba	Kimbanga	Nsundi	Nsaku
Kimata		+	+	-	-	+	-	-	-
Mbanza Nlele		+	+	-	-	-	-	-	-
Nseke Kai		+	-	+	+	-	-	-	-
Kimuanza		+	+	-	+	+	-	-	-
Kivunda		+	+	-	-	+	+	+	+
Mwanga Nlele		+	+	+	+	-	-	-	-
Nseke Mbanza		+	+	-	-	-	-	-	-

Clans of Kimata chiefdom, Manianga region, Lower Congo, twentieth century.

⁹⁹ Conversations with men of Kintadi village, October, 1965.

¹⁰⁰ Conversations with Bazola Samuel and his friend Jerome, 1965.

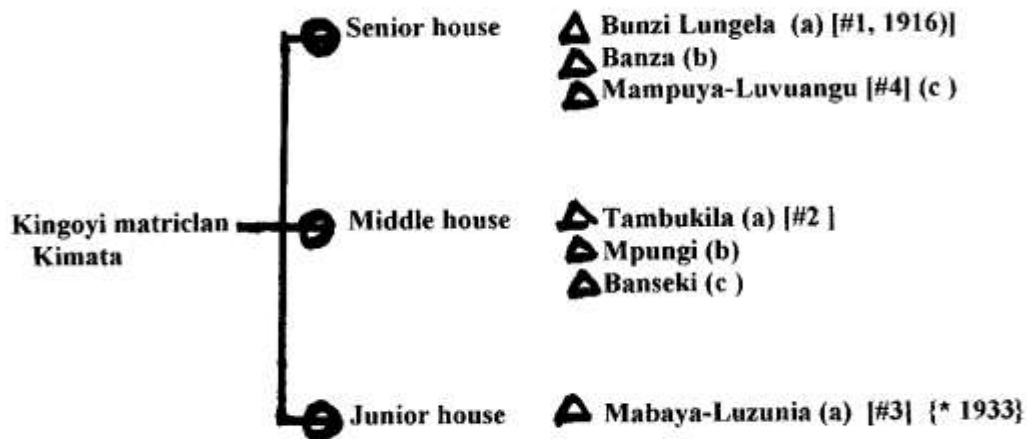
¹⁰¹ Janzen fieldnotes IV.B.23-24.

¹⁰² Kingoyi origins, according to Vercaeye's inquiry in 1933, were said to be similar to those of Kinsaku.

¹⁰³ From the word *zimbalala*, which means "to disperse."

The region was one in which Western Equatorial Bantu symbols and settlements had been overlaid with a somewhat southerly set of symbols, whose main insignia of centralized power had been so to speak indigenized. Perhaps Kingoyi's Mpu title, once received from Nsundi or Nsaku NaVunda, now needed to be renewed by the current alliance partners and patrifilial children, since the centers of the Kongo kingdom and its province Nsundi had long ago disappeared. When Belgian colonial agents established the Kimata chiefship in 1916, they seem to have been clear in their minds that Kingoyi clan should have the medallion chief. The table below shows the colonial medallioned chiefs of the Kingoyi clan of Kimata amongst the chiefs of clan sections (mfumu belo).

The third holder of the medallioned colonial chiefship, Mabaya-Luzunia, was deemed in 1933 by a prominent diviner to require investiture to the mpu because "he was sick." The account of this investiture, to which we will come below, is available to us today because then Belgian colonial agent O. Vercraeye studied it carefully to understand indigenous authority.¹⁰⁴



Chiefships in Kingoyi clan of Kimata, North Manianga, 1916 to 1950s; successive mfumu dikanda, a,b,c; mpalata, #1-#4; mpu, *. Sources: Interviews with 1960s clan members; Territorial records.

It was not uncommon in the precolonial and colonial setting of Lower Congo for individuals to accumulate several titles. But the particular conjuncture of the mpu and the colonial medallion chiefship was potentially filled with contradictions. The mpu, in the several other settings related earlier, represented a certain disenfranchisement or marginalization that was transformed into religious power, as in a cult of affliction, through an appeal to the ancestors. One may wonder, in a case like this, whether the colonial authority of the medalled chief contributed to the sense of alienation, calling for the mpu investiture? It may be that the Mpu was endorsed by the colonial authorities to enhance and further legitimate their regime.

¹⁰⁴ È O. Vercraeye, Report of *Mpu* investiture of Mabaya, AIMO/C2, P.V.#135, 20/8/33 Luozi Territorial Archives (XLA.38-44). Mabaya had been in trouble with the colonial government before this. The Territorial Administrator received a letter (14/4/1931) from District Commissioner Mertens in Boma authorizing him to withhold two months' pay from Mabaya for "s'etre desinteresse de l'entretein des villages de la chefferie et de l'amenagement des chemins vicinaux". Invested chiefs could not be "condamne" according to article 28 of decret 2/5/1910.

Vercraeye's judgement was that formerly each village was inhabited by one or several clan sections, living its life as a village alone and apart as a political unit, each under the authority of its chief. Sometimes a clan would divide into two or even three units or *bibelo* each with its own chief. But among these one individual would be a particularly adept spokesman and this would give him a certain ascendance over his peers.

The narrative of colonial agent Vercraeye suggests that he believed that a "royalist" model would best fit the Kimata group, in which only one *belo* line would hold power. However, evidence shows that the people in these sister *bibelo* communities wished to share power as a commission in which each *belo* would hold office in turn.

It is difficult to know how powerful, or substantive, the Kimata chiefship may have been before the Belgian colonial government recognized it and endowed it with its own title. The region was located along trade routes between the large market of Mpumbu at Malebo Pool and the ocean. Local memory and names give evidence of wealth in cloth, guns and slaves. Vercraeye interpreted the use of the title *ta mbanda* to be derived from the bands of iron used to tie up the packages imported by the caravans from the coast.¹⁰⁵ But the memory of the trade remained in their clan epithet which alluded to "our mother, the palm sapling, which brought European cloth, guns and iron upriver from the coast".¹⁰⁶ In any case, the junior line was recommended for the Mpu, through the divination on Mabaya.

Calming the land: the mpu investiture as healing rite

Mabaya, sick since a long time, was told by the *nganga ngombo* diviner Babahoka of Mpete village, Kimbimbi region, that he would be healed only if he were invested to the Mpu".¹⁰⁷ On Konso day all the men born of fathers in the Kingoyi clan of Kimata, were called together to give their father Mabaya the Mpu so he might be healed. Konso is the most auspicious of the traditional four-day Kongo market weekdays, often associated with sacred rites, events, or sites. Here it was the time of purification.

The patrifilial children of the men of Kingoyi-Kimata came, they drank wine, and got to work cleaning the path to the cemetery. The ceremony was not however held in the cemetery, because of Mabaya's ill health. Rather, they brought him out of his house, leading him by hand to a mat near the Mbazi, the place where conflicts are resolved. There he sat down cross-legged and one of the patrifilial children," calling for silence, announced:

mwana

assistant

¹⁰⁵ Vercraeye, *op. cit.* This association between the role title and the iron packing band seems dubious. The bands were undoubtedly brought inland for attaching gun barrels to stocks, but the term "mbanda" is a much more widespread ceremonial title than the Kingoyi clan: it was the role term of the Lemba cult priestess, and elsewhere, earlier and closer to the *mpu* holder in the Kongo kingdom, the king's counsellors of the Nsaku ne Vunda clan, priests of the earth, were called Ne Mbanda-Mbanda. J.Cuvelier, *L'ancien Royaume de Congo*, p.305.

¹⁰⁶ "Mama goyo ntende, watombula *mputu* kuna maza, goyo ntende watombula mata na nkanda". Vercraeye, "op. cit.", 31/8/32 (XI.A.34-35).

¹⁰⁷ This entire section is taken from Vercraeye's account, with some commentary.

Bimbi, Nsungu, Bayaya.	Bayaya.
Nguba ngiene	Ngiene
I have groundnuts	
Makaya ngiene	Ngiene
I have greens	
Sudia ngiene	Ngiene
I have pepper	
Nsusu ngiene	Ngiene
I have a chicken	
Ngulu ngiene	Ngiene
I have a pig	
Mbwa ngiene	Ngiene
I have a dog	
Malafu ngiene	Ngiene
I have wine	
Bima nyonso ngiene	Ngiene
I have all things	

The assistant repeated the "Ngiene" call three times and sat down cross-legged funda kata as the chief. A priest from among the patrifilial children took the ceremonial opening medicine (mabonzo) of malemba-lemba, mumpoko, and roots of ntondo and the palm, in which a bit of mpemba white earth and kala charcoal has been tied up. Dipping this in water, he approached the chief and sprinkled him.

These colors and plants reveal the Kongo theory of cosmology which lies behind every consecrated medicine or ritual inauguration. These ingredients are together often called nkisi, which means the composition and application of knowledge in the creation of a chemistry of efficacious material or human wisdom. Mpemba, drawn from white chalk of the riverbed, always represents the hallowedness of ancestral presence, the beyond. Charcoal, kala, represents the confusion of the human world, and which stands in contrast to mpemba. The plants in the asperge all have to do with the mediation of these two realms in the cosmology. Lemba-lemba, which is planted at the entrances to villages, tranquilizes, calms (=lemba); Mumpoko, a wild plant, mediates the domestic and the wild; ntondo and diba are parts of the palmtree, a plant of ancient uses and meanings connecting the two realms. In applying them to the purification of the Mpu" chief they signify his preparation as an emissary of the beyond in the world of the living.

Turning toward the candidate, the assistant repeated "Bimbi, Nsungu, Bayaya, nguba ngiene ..." The priest among the patrifilial children then cleared his throat to make himself important and all repeated this. Pouring wine and water on the mabonzo asperge, he placed a hand on the head of the chief, pushed him back slightly, with the other hand he squeezed the asperge so several drops fell into the chief's mouth while he incanted:

Nganga	Assistant
E tata, tata	
Oh father, father	
Mpemba nkuluntu	Mpemba nkuluntu

Sacred Elder of the 'white'	Elder of the 'white'
E tata, tata	
Mpemba nkuluntu	Mpemba nkuluntu

Then followed the ceremony of ntoba, the earth brought from the cemetery of the clan ancestors, mixed with palm wine and water. Taking this mixture the nganga incanted:

Tusa mamba
 We pour water
 Tusa malafu
 We pour wine
 Ntsi ma muene tulemba
 The domain of the Sir we calm it.¹⁰⁸

The forehead, the temples, and the entire body of the chief were annointed with ntoba cemetery earth. When this was finished, the nganga cleared his throat and all present imitated him.

Then the drums sounded, and guns fired bizongo salvos to honor the candidate, and the children rejoiced with wine and food offered them by their Father.

The purification of the candidate and the earthly domain, the Nsi, has been completed. Water, palmwine, and cemetery earth from the Kingoyi ancestors brought into full integration the channel from the human to the ancestral realm. It also opened the human community to the power of the earth, and prepared the way for the final stage of the investiture of the chief at a later date. In other accounts of the Mpu investiture, the candidate spends up to a month in ritual isolation before the closing event.

Two days later, on Mpika, the ceremonies of Sunga (armband), Lunga (bracelet) and Mpu (hat) were observed. Again the chief was brought out of his house by the patrifilial children to the mat in the mbazi courtyard. [Mpika is the antipode to Nkonso. In a cyclical or temporal application of the cosmology, it represents the bringing of power into the ground prepared during the rite's opening on Nkonso day.] The priest opened the rite with

Bimbi, Nsungu, bayaya...
 and sprinkled the chief with his asperge. Making a sign to the patrifilial children, he announced:

Tata Mbanda
 Father Mbanda
 Tata Mbanda
 A wele
 He goes
 Kobila.

¹⁰⁸ The "calming of the land" may well be a very ancient, very widespread rite in Central Africa. Steven Feierman, *Peasant Intellectuals*. (Madison: Univ. of Wisconsin Press, 1990) describes a very similar rite among the Shaamba of coastal Tanzania, *zyfya nsi*

to bathe.

This was repeated by the chorus of those present. Several patrifilial children picked up the chief, carrying him to three successive crossroads of the village. At each one they stopped, and the nganga repeated:

"Mbimbi, Nsungu, Ba Yaya..."

Then they returned and placed him on a leopard skin that had been put on the mat where he had sat before. Just as the temporal cycle brought the ancestral white space into the midst of the human community, so now the circular course of the sacralized chief past the village entrances brought the power symbol of the leopard skin into the conventional courtyard, in a kind of amplification of authority. Then the priest, with armband, bracelet, and crown in hand, advanced a-jumping toward the chief. Balancing the three insignia he announced

E kamba a gangu	
Speak about it	
nza watambula wau	
Come fetch [insignia]	E wa wawa!

The priest returned in his tracks and again repeated the procedure. He then attached the armband to the left arm of the chief. Again he returned, chanting the same words, and put the bracelet on the left wrist of the chief. Finally in the same way he put the hat on the head of the chief.

Now there remained only the giving of the chief a new name. This exchange was central to this part of the rite:

nganga	assistant
Bimbi, Nsungu, ba yaya	
Yandi luzebi nkumbu?	Aha aha! Do you know his name?
Yandi luzebi nkumbu?	Aha aha!
Do you know his name?	
Yandi Manswame?	Aha aha!
Is he Manswame?	
Yandi Maweza?	Aha aha!
Is he Maweza?	
Ta Mbanda, Ta Mbanda	He he he!
He's called Mbanda	
Ta Mbanda.	Heeeee.

And again gun salvos were fired. When all was quiet, an old patrifilial child arose and pronounced the following mwina or longo interdictions for the new chief.

Now that you are chief
 That you have put on the Mpu
 You will not cultivate the earth
 You will not dig up peanuts

You will not draw palm wine
 You will not carry palm wine
 You will not harvest mushrooms
 You will not eat bloody meat of an animal killed that day
 You will not eat leopard
 You will not eat kinkanda monkey
 You will not lead pigs to market
 You will not plant banana trees
 You will not eat palm nuts
 You will not eat palm almonds
 You will not break palm nuts
 You will not carry anything on your head.

After these interdictions were pronounced, the same patrifilial child announced

Tata wayenda
 Father is going
 Naku nanguna?
 Who will raise him?

He moved a-jumping toward him, taking the chief's little finger of the right hand, and while he rose the two together raised both hands into the air. The patrifilial child cried out, and those present replied

ana simu	tela
children of the shore rise	
lubulubu	lubu
lubulubu	lubu
ana simu	tela.

At that moment the chief jumped up, feet together, leaving the leopard skin. The ceremony was finished. [This jumping is a sign of contact with "the white" of spiritual power. The "children of the other shore" are probably the onlookers, the patrifilial children, as bystanders, who are invited to behold this display of ancestral energy before them. Simu Nzadi, the shore of the great Zaire (=Nzadi) river, is an analogy that refers to the river of death, and the sight across this river of one who has "passed over." This final scene of the sacralized chief is reminiscent of the rites of purification, of healing, and of the "weighing of the spirit" among Manianga prophets in the late twentieth century. These performers of the spirit compare the tension between the sacred and the profane as "electricity", which is so powerful that one who has it can hardly be touched. The appropriate posture in approaching contact with such an empowered one, is this a-jumping described here, dumuna. In a poignant finale, the energized Mpu chief is suspended in mid-air as the ceremony ends.]

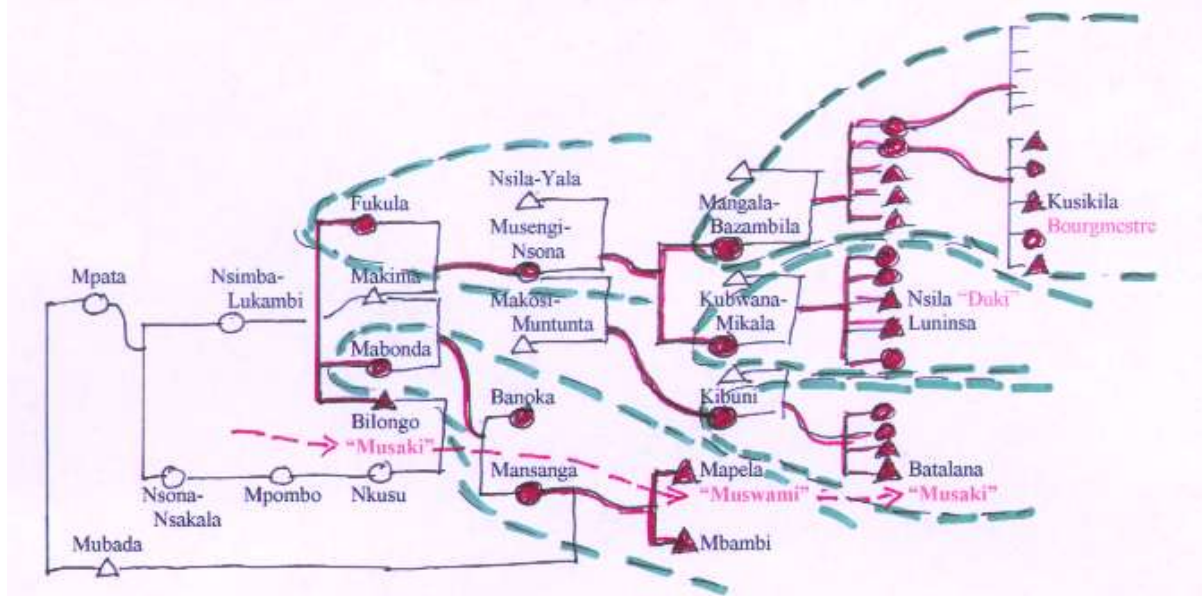
The creation of the Mpu chief entailed further and sustained obligations for the patrifilial children. They must pay a tribute called budi dia mfumu, a part of each harvest and of the animals killed in the hunt. They must carry for him everything he needs on his

travels; they build and keep trimmed his lumbu enclosure and build his house therein. The entrance to the "lumbu" of Mabaya was forbidden to all adult freemen (mfumu kanda) of the Kingoyi clan. Patrilineal children were on hand as courtiers, nkengi a lumbu, to watch over the chief, kenga mfumu mpu.

A very similar, but less fully detailed, account of an investiture to an Mpu chiefship, is available from Madzia, across the border in the former French Congo eastward of the Kimata setting. Recorded in ca. 1910 by Kongo catechist-ethnographer Bitebodi Andela, it underlines the relationship of the suffering chief to healing and the alliances of the patrilineal children to the chiefly line.¹⁰⁹

Nsundi of Nseke Mwini: Christian Replication of a Buried Chiefship (1957/1965)

Batalana had in his youth been designated to become the successor of the reigning *mfumu mpu*, a chiefly office whose purpose was to "safeguard the clan's spiritual interests and to maintain contact with the ancestors, a task shared with the collective patrilineal children."¹¹⁰ Batalana was however never inaugurated to the *mpu* because his forebears



¹⁰⁹ Bitebodi Andela, "Mbiadulu cimfumu cia ntoto" [investiture of the chiefship of the earth], Cahier # 26, Laman Notebooks, SMF Archives, Stockholm, Sweden. ca. 1910.

Mbiadulu zena bonso bebu, watata nti bela ka bele bakwe fielesa nkakala kwa nganga, nganga buteka taka, empu yenandie, ndikateno mpu mboko handisa. Bu, bakwizi wata, buna batumisi bala bambuta natatekolo: Bu bakwiza bakwe bongu mubombe, nidiata beka kwe diati mu nitu yonsoni, bu ba kwe diati nibu bakwete, mpwa tata kana kudiata yo... Bu ba mani ya diata, kabonga kani nsusu kani ubaveni. Watalanti nitu yicimini, buna kavulu batumisa, bakwiza vo bayuyulu mucina mpimpa ya nkaka. Mbazi minciela bubu eka cia, bakwenda kuvoka batula va mukala wadiamina mfumu abiala, babongele ntoto, bakwiza kuvata babonga bilongo bia sabu batebele bavukidi na mfumfula za ntoto bakangidi va nsinga nkampa, basisi nsungua miolo na wa Malela [?] na wa ngudia mfumu, Malela ni nati cia nkutu. Baba mwisi Kikwimba buna bamutele, Mikwimba. Kaba mwisi Kaunga ba mutele Miaunga, nanso kanda dikena niyina bamuta, nanso nkumbu yibi biadi laka ni yina kabiadila. Bweka bo bakazi bandi nitukula beka mu yobesaka, kalende vutu zeba ko. Lumbu bu bifwana bakwe mudukisa buzandu, bamana sa kimbela bakwizi kadi, kabaka bitwizi veni bala ba mbuta na batekolo. Babonga nlunga bamu vwika buna yuandi weka mfumu a biala.

¹¹⁰ J.M. Janzen, *Quest for Therapy in Lower Zaire*, p. 116.

decided to abandon it, since they had become Christian. The insignia – a bracelet and a cup – were buried with the elders, perhaps the man who had picked him when he died in 1957.

Batalana and his family did not think much about the *kimfumu mpu* until years later, in the 1960s, he became ill with chronic asthma. For some years he sought treatment in a range of biomedical clinics, but the asthma always recurred when he resided for long durations in his home matrilineal village, Kisiasia. In due course he sought the counsel and divination of a Christian “prophet” in the Protestant church, who indicated to him that the cause of his asthma was in his extended family. Meanwhile, the deaconship of the small Protestant congregation in the Nsundi section of Kisiasia had become vacant. The local congregation designated Batalana to fill this position of spiritual leadership. They dedicated him one Wednesday evening in the village church and officiously declared that by this election they were “giving him permission to be healed.” Such an official group pronouncement was common in group confessions where human cause was suspected. Following this meeting, Batalana took up residence with his counselor prophet and returned only to cultivate and harvest his crops.

Although various members of this lineage thought that Batalana’s chronic illness was due to current conflicts rather than the *mpu*, it was not difficult to discern the structural similarities of the historic *mpu*-ship within the Nsundi clan section and Batalana’s and his line’s placement in local authority. Likewise, the association of the election to the deaconate with being healed of his sickness paralleled the common association of sickness with election to inauguration to the *mpu*. The investiture in effect became the cure for the candidate and the society.

In the local Nsundi clan section to which Batalana belonged, other offices included the village headman, *duki*, held by a member of the middle “door,” of colonial origin and it continues into the postcolonial era. The title of communal *bourgmestre*, which happens to be held here by a member of the senior door, is of postcolonial origin, replacing that of sector chief. The office of *duki* in this small Nsundi hamlet also served as the office that elsewhere might be called lineage head, *mfumu dikanda*, a more traditional precolonial office that served to represent the local land-owning cemetery-centered clan section. For present purposes it is the *mpu* that is of greatest interest, and in a way best reflects the tendency in Kongo political culture to offset power concentrations of power with an appeal to spiritual authority from the ancestors. Whereas “secular” power tends to gravitate to the senior line, the offsetting spiritual offices of authority such as the *mpu* tended to follow the junior line. These varied factors that tie clan section structure and the distribution of offices of authority, the prevalence of off-setting the secular authority of the senior house with a more spiritual, ancestrally chosen, office in the junior line, and the association of the latter election and investiture with sickness and healing, all recur in the next two examples.

Kimbanga of Kisiasia: Self-Empowerment through Kongo Prophetism (1965 & ff)

My contention that the precipitating causes of such a ritualized cure/investiture had more to do with structural ambiguities within lineage corporate groups than with a cultural tradition –although that is certainly there–is borne out in a third example of a North

Kongo local clan section. The Kimbanga of Kisiasia, in their political culture, reflect a more northern Teke, or Tio, heritage (thus non-Kongo); the *mpu* tradition is altogether absent. Their earth spirits and ancestors are identified by the notion of Kinda, or Bikinda, the name of their cemetery. Yet in this case we can very clearly see **[Kimbanga genealogy]** the nature of the growing contradictions as the local lineage of three “doors” becomes ever larger and the principle of dialectical and successive tenure of headship is increasingly difficult to attain, as other junior lines assert their autonomy. The explicit numeration of the sequence of the lineage head title holders (see numbers over names of office holders in accompanying charts) indicates the sequential holders of the headship of the large Kimbanga clan section with historic residence in this area dating from at least the 18th century. Note that these title holders oscillate between elder and junior houses, in the following manner: 9-10 (senior), 11-12-13 (junior), 14-15-16-17 (junior of senior), 18-19-20-21 (junior of junior), 22 (senior of senior), 23-24-25 (senior of junior, # 25, Sobisa, a bright literate young man at beginning of colonial era, governs from 1919-1957), 26 (junior of senior, but dies in office soon after taking over), and 27 (senior of senior). The gray line surrounds junior of the senior line many of whom have become members of the Church of the Holy Spirit in Africa. **[Nzuzi celebrates Sobisa]** In the absence of the *mpu* or any alternative authority role, the large junior branch of the senior line demonstrates its alienation from authority by joining the most dramatic of the Manianga prophet churches, the Church of the Holy Spirit in Africa **[ngunza meeting] [rites of DMNA]**, whose liturgies of “healing,” “weighing of the spirit,” and “annointing” are comparable to those of the *mpu* or other sacred chiefships of the Kongo. Note especially the similarity, in the account above, of the final rite of Mabaya’s investiture to the *mpu*, described in the words below, with the rite of “weighing the spirit” in the DMNA (see figure 1.8).

The meaning of *dumuna*

Then the two joined their hands, and the new chief jumped into the air while those present cried out to the “children of the other shore” of the river of the dead. The concept and ritual of *dumuna*, or *sala duma*, provides the scholar of Kongo political culture with a clear insight to the interrelated meanings that come together in the *mpu* chiefship and the authority that it enacts.¹¹¹ Both literal and figurative meanings are associated with the transitive verb *dumuna*: to make jump; to struggle with, to remove and turn over on the ground; to mount a horse, to fall to one’s knees; to let (a bird) fly away, to run; *dumuna nuni*, to bring a first-born into the world. *Dumuna* is also the name of a consecrated medicine *nkisi*. In its passive “neuter” sense, *dumuka*, in addition to its meaning of being jumped, bounded, or caused to fly, it can mean to cause a startling, “crackling” feeling of suffering; to feel one’s pulse beat in suffering; or something that pulsates in the body in affliction. It may also mean to raise dust, and finally, to return home after the death of kin who have died in a foreign land.

Restoration of Authority as Healing

“Reading the signs” of affliction and healing in these three lineage communities has identified a thorough-going pattern that includes: (1) the use of signs of sickness to

¹¹¹ Karl Laman, *Dictionnaire kikongo-français* (Brussels, 1936).

recruit to a position of authority, (2) the transformation of the identity of the sufferer to that of ruler or priest, (3) the healing of the community and its alliances as the sufferer is invested to office of authority; (4) the empowerment of a junior or marginal segment of the community by renewing an alternative office of authority.

“Reading the signs” here entails comprehending elaborate social referents, and the association of collective well-being with overcoming the sickness and health of individuals. It is the well-being of the community that is at stake, and the perception that social disintegration or crisis is manifested in individual sickness. Anthropologists and other observers of these situations must cultivate open-mindedness about the directionality of the association of sign to referent: Is the social condition the metaphorical ground for and of individual affliction? Or is the afflicted individual a metonymic particularization of social contradiction that is being resolved through the empowerment of the alienated junior segment? Perhaps we are looking at a social tradition, aided by many particular divinations, in which individual affliction reflects the social condition in which the body of the *mpu* novice priest or the *ngunza* prophet becomes a metonymic particularized instance of social renewal.

Chapter 9

NGOMA

A WIDESPREAD SUB-SAHARAN AFRICAN THERAPEUTIC INSTITUTION

You have now been exposed to a range of features of Central (Eastern, Southern) African therapeutic modes and institutions. In this chapter I want to consider one of the most widespread institutions, namely that approach to healing often associated with drums and song-dance (whence the widespread distribution of the term ngoma [**from Ngoma**], initiation to a network or group of healers with the same affliction; entrance into a lifelong relationship with the spirits of that affliction. Sickness is a sign of recruitment to social office. The sufferer may become a healer. Marginality is embraced as a source of power. [**Woman in Mpombo seclusion**]; The modes of affliction in these ngoma networks (or cults of affliction, as Victor Turner called them) may be specialized, separate from divination, as in northern Zambia (e.g., lack of hunting luck with the bow and arrow vs. lack of hunting luck with the gun; various type of women's reproductive disorders) or undifferentiated (as in the Nguni-speaking south, where there is one mode called sangoma), with **divination included in the work of the sangoma**, as well as dealing with the spirits.

I draw on several examples from the vast and ever expanding repertoire of *ngoma*-type healing networks around Central and Southern Africa.¹¹² The first of these is twinship within the context of fertility concerns on the southern savanna; the second is an historical ngoma that emerged on the Congo coast and inland in the 17th century around the destabilizing threat of the trade, and the effort to contain the socially disruptive

¹¹² The lecture format necessarily limits a review of the vast body of scholarship on Sub-Saharan African cults of affliction to this footnote sketch. I have recently provided a bibliographical essay for my Revised 2nd Edition of MacMillan Encyclopedia of Religion, 2003, at the close of my entry on "African Cults of Affliction." A short list of key works that continues to guide my analysis and writing on the topic includes: Victor Turner's work on Ndembu ritual is the best starting point, beginning with his *The Drums of Affliction*, Oxford, 1967, and other monographs such as *The Ritual Process*, *Chihamba*, *the White Spirit*, *Divination and Revelation*. Terence Ranger, Richard Werbner, and Wim van Binsbergen all conducted research on regional aspects of ngoma and moved theorizing ahead. The volume *Regional Cults: 1977*, ed. Richard Werbner, began the critique and additional review of the idiom. My two regional projects on ngoma were, first, *Lemba, 1650-1930: A Drum of Affliction in Africa and the New World* (Garland, 1982), a historical examination of the circumstances of the Atlantic slave trade, and from there to take scholarship beyond static ritual perspectives to deep historical as well as urban modern settings in Western Congo, Dar es Salaam, Swaziland, and Capetown. This was published as *Ngoma: Discourses of Healing in Central & Southern Africa (California, 1992)*. A group of Dutch anthropologists headed by Matthew Schofeleers reviewed my research and published their own studies in *The Quest for Fruition through Ngoma: The Political Aspects of Healing in Southern Africa*, 2000, eds. Rijk van Dijk, Ria Reis & Marja Spierenburg; The best recent monograph on the topic is by Boris Wastiau, *Mahamba: the Transforming Arts of Spirit Possession among the Luvale-Speaking People of the Upper Zambezi*, 2000. Research on ngoma is now in the hands of a new generation that has become more theoretically specialized as well as geographically globalized. Studies are being done, and published, that look at ngoma as protest, the importance of a historical perspective, in relation to postcolonial states, as music, as spirituality, in relation to war's victims, and as an infrastructure for health care and health education.

impact of individualistic mercantile accumulation into a society whose ethic was rooted in kinship exchange and distribution; the third example is an ecological or environmental threat, namely poisonous vipers of western Tanzania; the fourth is the undifferentiated ngoma cells and networks of township life in Apartheid Capetown South Africa. These examples illustrate the range of issues that are addressed in this widespread and ancient institution of ngoma.

Twinship is of course very widely recognized across Central and Western Africa as requiring special attention, either of a pragmatic sort about the equitable raising of twins, or more often that it is a metaphysical circumstance requiring elaborate ritualization. **[Twins]** On the Southern Savanna twinship is recognized within the larger concern for fertility and a history of at least several centuries of widespread fetal wastage.¹¹³ In Victor Turner's classic work on drums of affliction among the Ndembu of northern Zambia, fully a third of the twenty "drums" were devoted to reproductive issues, particularly in women.¹¹⁴ Yet it was twinship, or multiple births (since triplets and quadruplets are also "twins") that provided the paradigm for the incorporation of birthing and reproductive issues into the ritual framework of the *ngoma*: the discernment that with twins the parents must be initiated into the network of fellow parents of twins, and receive the instruction pertaining to this condition, and gain a knowledge of the spirit world. As Victor Turner so eloquently explained, and this is echoed more widely in other settings, twins were two in one, they were an instance from lived experience, of the juncture where the visible and sensory multiplicity of human experience touches the invisible and abstract unitary world of the spirits and the divine.¹¹⁵ Turner also suggests that the perception of twinship that drives it into the same class of ritualized activities as failed or troubled conception, is its aspect of departure from the normal on the side of abundance. Thus, too much, just as two little (or troubled) fertility, brings on the aura of requiring intervention toward the ancestors, and solidarity with others who have experienced the same thing. Our narrow Western categories of sickness quickly prove inadequate here. As anthropologists we realize we must once gain take note and pay careful attention to the signs and the referents of this ritualization.

Prominence of the metaphysical dimension of twinship explains the powdering in white of the **mother of twins** and her associate, perhaps her mother. Anointment in kaolin (*luvemba* or *mpemba*) signifies liminality vis-a-vis the world of humans, a ritualized rapprochement with the spirit world. However, the **mother of twins on the right-hand photo** is equally liminal, although not anointed. I was told that these were "Christian twins," no less special, at the threshold of the sacred in another religious tradition.

For a second illustration of ritualization in the *ngoma* mode, I turn to an area of experience that is jarringly different from twins and reproduction: **[the threat of**

¹¹³ Excellently documented by Anita Spring in her "Epidemiology of spirit possession among the Luvale of Zambia." In *Women in Ritual and Symbolic Roles*, Judy Hoch-Smith & Anita Spring, eds., eds. New York: Plenum, 1978, pp. 165-190.

¹¹⁴ V.W. Turner, *The Drums of Affliction*. Oxford, 1967.

¹¹⁵ Examined in Ch.2 "Paradoxes of Twinship in Ndembu Ritual," in V.W. Turner, *The Ritual Process*, 1969, but similarly spelled out in these terms by Ndibu Joseph, "Father of Twins," pp. 57-60, In J.M.Janzen & W. MacGaffey, *Anthology of Kongo Religion*. 1974.

poisonous vipers]. Yet in comparing these two examples of Central African experience, we are challenged to find the common, underlying logic in the *ngoma* mode of ritualization of life and experience. The presence and fear of vipers and poisonous snakes in Central Africa is far more widespread than the focused organization of ngoma ritual healers who, as in Western Tanzania, are organized into local cells of My material comes from Tanzania where there are in the west of the country well organized as *waganga* who are knowledgeable in snakebite antidotes and are trained to handle vipers and other dangerous snakes.¹¹⁶ The folkloric version of Mungano performed in Dar es Salaam is done by the national troupe one of whose members studied Mungano among the Sukuma and Nyamwezi. The folkloric version of snake handling does not get much beyond awing the public and inviting “volunteers” to come forward to be bitten by a lethargic (non-poisonous) boa constrictor that must be prodded to strike. All this to the accompaniment of drumming and song-dancing, as is expected in the *ngoma* idiom.

The example of Mungano as *ngoma*, seen through the folkloric version back to the living historic version in Western Tanzania, brings together cultural elements pieces Westerners might regard as highly incongruous: life-threatening vipers and poisonous snakes in a potentially hostile environment; serpent spirits that ostensibly possess the recruits, and must be placated by the novices; knowledge of venom milking, inoculation and immunization for the snake-handlers; antidotes for quick treatment of snakebite; song-dance public performances with snakes; a revered elite of *banganga* doctors who possess and transmit knowledge--technical and ritual--to the next generation of experts. There is however in the Tanzanian snake-handling ngomas a pronounced culture of acceptance of the reptiles that are otherwise feared. The ngoma includes the incorporation of the threatening agent and direct engagement with the spirits of the most dangerous snakes. This is the homeopathic resembling stance behind the technical transformation of venom into life-saving antidotes injections. The ill is counter-acted by embracing it rather than allopathically attacking it.

The third example of ngoma ritualization occurs in the townships of South Africa’s big urban centers during the era of Apartheid. [**Living under Apartheid**] In my work I focused on Guguleto, one of the notorious townships in greater Capetown. [**Doing ngoma in the townships**] A few framing perspectives will situate this example alongside the previous two. Here ngoma, although brought from the countryside, is fully urban in its manifestation, attesting to the genre’s flexible nature. In contrast to the highly specialized character of ngoma orders in Central Africa (e.g., women’s reproductive difficulties, poisonous vipers), here it is undifferentiated, all-inclusive. There is but one order of ngoma, and it cross-cuts all ethnic communities, under the shadow of Apartheid. Yet there were some features of ngoma practice in Capetown that were brilliantly illustrated and consonant with ngoma elsewhere, notably, the performance of song-dance, and the presentation of a range of chronic or crisis difficulties into the ngoma format. “Doing ngoma,” *sa-ngoma*, is the core ritual unit. [**Doing ngoma, core ritual unit**] It is comprised of an enunciation by one of the gathered *isangoma* (one who does ngoma) or *igqira* and their novices and patients. The declarative statement or call (*ukunqula*) is followed by the *ngoma* response, the song-

¹¹⁶ See *Ngoma*, 22, 34-35, 149-151.

dance in which the entire circle joins, along with drumming and rattles, or just clapping. This sequence of call and response sequences is choreographed by a senior, fully-qualified healer who understands the needs of particular cases. Such “doing ngoma” sessions may occur at any number of types of events that bring together the network of healers, initiates, and patients. The first example is from a novice, and the next two are from qualified healers.

Ngoma: Opening by leader: We have spirit...

Ukunqula: Ka Ngwane [ancestors], hear me...

Ngoma: Sing and clap for the crab next to the river.

Ngoma: He Majola, come out of jail. I have news of your house.

Ukunqula: You would have thought that the night ‘war’ would have calmed down this healer spiritually. But no, it doesn’t. I’m in it, always facing a white person [at work], and maybe that’s why I’m on edge.

Ngoma: The ancestors are sleeping at the top of the mountains of Ulundi.

Ukunqula: Let darkness be replaced by light. *Camagusha*. I thank being welcome in this home, *camagu*. I was coronated in this home, and the *isidlokolo* bushy hat was given to me here.

Ngoma: I love Jesus, he set free my soul.

Such a picture of ritualization -- embodied, emotionally rooted, articulating contradictory and intractable social sentiments -- is particularly helpful in understanding the existential core of suffering, healing, and struggles such as body transformations and loss of control that occurs in chronic and debilitating conditions, and social marginality.¹¹⁷

Reading the signs here requires the scholar, therapist, or health promoter to recognize the enactment of conditions often too complicated and painful to verbalize, or almost beyond words in their overwhelming and transcendent quality. The emergence of an ngoma-ized cluster of misfortunes, or steering a case into such an order, is an exercise in public multivocal (doing ngoma) discourse where incoherent yet powerful signs--of bodily suffering, dreams, verbal confessions-- are drawn out and articulated in song, dance, drumming, close physical proximity, mythic and dramatic reenactments that usually also rise to the verbalized statement. The combination of expressive forms becomes a cathartic culmination after the all-night event. In Guguleto, as in most *ngoma* communities across Central, Eastern, and Southern Africa, selected individuals rise from the stream of clients to receive diagnosis of the call to become healers. The ancestral call is affirmed, and the sickness is redefined as the first stage of the “course through the white” that leads to the sufferer becoming a healer. Of course, this requires several years of apprenticeship, and significant material resources paid in dues. **[transformations]** The transformation from sufferer to healer is often marked by a sacrifice in which the animal’s life is exchanged for the affliction, and the sufferer yields to the call. The liminal position of whiteness gives way to increased color and elaborate self-presentation. The sufferer/novice is incorporated into a network and if successful becomes the center of a new network that brings order and heightened exchange into the social fabric around

¹¹⁷ J.M.Janzen, *The Social Fabric of Health: An Introduction to Medical Anthropology*. (McGraw-Hill, 2002). See Ch. 5, "The Lifecourse: Birthing, Living, and Dying," and Ch. 6, "Personhood, Liminality, and Identity."

many instances and performances of individual transformation.¹¹⁸ **[networks & knowledge] [networks of networks]**

Conclusion

These three illustrations barely scratch the surface of the range of ngoma-type rituals of affliction and networks of support that constitute Ngoma as we understand it. A score of recent dissertations from recent PhD scholars in Africa, Europe, and North America.¹¹⁹ They have established themselves as a new generation of scholars that is raising a host of new issues pertaining to ngoma in Central and Southern Africa.

¹¹⁸ Harriet Ngubane, "Aspects of clinical practice and traditional organization of indigenous healers in South Africa," *Social Science & Medicine*, 15B (1981), 3, p. 363.

¹¹⁹ Recent dissertations on ngoma or aspects of it include: **Gearhart, Rebecca Kathleen** (1998) *Ngoma Memories: A History of Competitive Music and Dance Performance on the Kenya Coast*. PhD Dissertation, University of Florida. **Mtobela Guma**, a sangoma from the Western Cape, and now on the faculty of the University of the Western Cape, *The Politics of Umoya: Variation in the Interpretation and Management of Diarrheal Illnesses among Mothers, Professional Nurses, and Indigenous Health Practitioners in Khayelitsha, South Africa*. PhD Dissertation, University of North Carolina at Chapel Hill., 1998). **Tapio Kauko Risto Nisula**, *Everyday spirits and medical interventions: Ethnographic and historical notes on therapeutic conventions in Zanzibar Town*. PhD Dissertation, Tampereen Yliopisto (Finland), 1999. **Julie MacGruder**, (Zanzibar) *Madness in Zanzibar: „Schizophrenia“ in Three Families*, PhD Dissertation, University of Washington, 1999; **Stanley Moore**, *Indigenous Medical Practice and Knowledge in the Medical Culture of Dar es Salaam*. PhD dissertation, University of Kansas, Department of Anthropology, 2000. **Sue Schuessler**, *The Children of the Crocodile: Grieving and Healing in Southwestern Zimbabwe*. PhD dissertation, University of Kansas. **Gabriele Mosegig-Pauleschitz**, a Viennese educational counselor who initiated sangoma status in Swaziland, and defended her dissertation as: *Sangoma. Das Werden einer Heilerin in Swasiland*. University of Vienna, 2003. **Hennie Blokland** (Tanzania), *Drums and Sacred Power*. PhD Dissertation, University of Leiden. **Jessica Erdtsieck**. (Tanzania) *In the Spirit of Uganga: Inspired Healing and Healership in Tanzania*. PhD dissertation, University of Amsterdam, 2003.

Chapter 10

THE IMPORTANCE OF TRAUMA HEALING IN OVERCOMING CYCLES OF REVENGE AND VIOLENCE ¹²⁰

This lecture has two broad goals of vital concern to the pictured refugees and millions like them who have been traumatized and most likely displaced by war [**Rwandan refugees**]. The first addresses anthropological disciplinary perspectives: Whether there is a distinctive contribution that anthropology might make to the understanding of war-related, war-derived, trauma? If so, then what are those perspectives, questions, methods of study, and analysis? Who are the authors, what are the studies, already in hand to guide the way? The second goal is a substantive, practical issue, an imperative I brought home from work in post-war, post-genocide, Great Lakes Central Africa. Namely, How can one promote the healing of the wounds of war so as to lessen the return to continuing cycles of violence? This question rests within an assumption, which also needs to be examined. Unless war trauma is healed, the cycle broken, it is likely to continue in the form of revenge killings, more war. Back to that in a moment, with some examples.

Anthropology, and specifically medical anthropology, has been hard at work in recent years developing a perspective on violence and trauma that is distinctive [**Anthropological Questions about War Trauma**]. Here, as in many other areas of anthropological work, there is a hesitancy on the part of scholars to draw a reifying fence around this subject matter. Anthropologists may on occasion use such phrases and labels as Post-Traumatic Stress Syndrome, trauma therapy, memory construction, or other semi-contextual technical terms, tend to avoid pinning labels onto particular cases. The open-ended, comparative and contextual perspective that anthropology provides, that bring out unique and varying clusters of cultural, social, political, and human features and factors, seems uniquely suited in identifying just what is going in a particular instance of violence and trauma.

Despite this shyness of anthropologists to provide hard and fast definitions, I will offer a sketch of what I mean by trauma, one of the key terms in our topic. Of course it includes physical trauma, as used in the emergency physicians in our hospitals. But we need to understand it so that it also includes trauma that leaves no physical marks, e.g., threat, psychic shock, chronic fear and anxiety, and such feelings as survivor guilt of someone whose entire family may have been massacred, or who may have witnessed someone else

¹²⁰ Readings for students included: "Six Families of Kayenzi," from *Do I still have a life?* J.M.Janzen; "Illusions of home in the story of a Rwandan refugee's return," from *Coming Home? Immigrants, refugees, and those who stayed behind*. Ellen Oxfield & Lynellyn Long, eds., University of Pennsylvania Press, 2004.; "Religious healing among war-traumatized African immigrants," J.M.Janzen, A. Ngudiankama, M. Filippi-Franz. In *Religion and Healing in America*, eds. L. Barnes & S. Sered, Oxford U. Press, 2004.

being tortured or killed, but who did not personally experience such things. Trauma is considered short-term or long-term, it may leave victims numbed or affectless, incapable of finding any interest in life or daily activities. Such trauma may leave long-lasting scars and memories that return in nightmares, dreams, or sheer physical anxiety from association with anything that reminds of the initial provocation. So you see, there is plenty to cover here, and where war has erupted, it is the survivors who are the victims of trauma. Africanist medical anthropology has in recent years contributed significantly to the study of post-war and violence related trauma.

The Wars in Question

In preparation for this lecture you have read about the community of Kayenzi in Central Rwanda, which we will examine more closely. You have read about one particular refugee who fled from Rwanda and returned. You have also read about Somali and Central African refugees in the United States and how they have, or have not, found “healing” from their war experiences.

I will consider the anthropology of violence and trauma in connection with a series of conflicts that are centered in relations between Tutsi and Hutu in the Great Lakes region, otherwise known as Rwanda and Burundi. But this conflict, which has erupted numerous times in recent decades, is part of a longer-lived crisis that has radiated out westward from the nuclear area of Rwanda and Burundi to especially neighboring Congo, eastward to Tanzania, and southward to Angola and Zambia. Furthermore, has had echoes in other regions as far away as Sudan, Zimbabwe, and even U.S. and France. In fact, it has been called All African War I.

You have read papers about Rwandans, Burundians, and Congolese and Ugandans in this conflict. We will trace it to 1994 when the so-called Rwandan genocide began.

[War Map I] In April, 1994, the international effort to achieve a reconciliation unity government was broken by the shooting down of the aircraft that carried the presidents of Rwanda and Burundi. Within hours, the massacre of Tutsi and moderate Hutu by Hutu militants began that ended with a million killed. The Rwandan Patriotic Front (RPF) simultaneously began its conquest from Uganda, resulting in the flight of up to four million-- militants, the national army, the old administration, and many of the populace.

[Map of War II] North Kivu refugee camps in Zaire along major roads leading north and west of Goma, drawn for United Nations High Commission for Refugees (courtesy R. Van der Meer). Camps of up to 250,000 persons are located along main roads in Zaire.

[Map War III] Map of refugee camps, South Kivu UNHCR - Bukavu, working map by N.E.Njuguna, November 28, 1994 (courtesy of R. Van der Meer). Note camps Muku (Bugobe) (5 kms), Mushweshwe (13 kms), Bideka (34 kms), and Izirangabo (at 47 kms) from Bukavu

[Mushweshwe, Charabare Camps]

[War Map IV: Kibimba] This map of one community in Burundi—a Quaker mission and surrounding homesteads—shows a pattern of polarization, flight, destruction, and regrouping, the Tutsi women and children in an ad hoc fortress at the top of the ridge under the protection of the army, the Hutu hidden in the valley forests with Hutu militants. Few buildings are serving their originally intended purpose.

[Kibimba church-displaced camp, inside church]

[War Map V: Bujumbura] Map of Bujumbura, capital of Burundi. Lake Tanganyika offers a major inland waterway. Bujumbura an important trade hub of the entire Great Lakes region. Tutsi militia succeeded in ethnic cleansing most urban townships by 2003.

[War Map VI: Congo 1997-1999] The Great Lakes conflict spread westward into the Congo in a complex way from late 1996 to 2000. At the beginning of this period the old Rwandan genocidaire government and troops and the militias were in Kivu, Eastern Congo. The RPF (new Rwandan government) wanted to create a buffer westward to prevent attacks. They fostered or supported a Congolese rebellion against Mobutu, first among the Congolese Rwandans the Banyamulenge, then more widely, and named Kabila as its figurehead. This rebellion gained momentum, and

[War Map VII: Darfur in Sudan] Tens of thousands of Darfur Sudanese are internally displaced and refugeed in Chad following raids on their villages by nomadic horse and camel militia with semi-automatic weapons. The Darfur region is ethnically complex. Inhabitants are sedentary cultivators, semi-nomadic “Arabs,” and semi-nomadic “blacks.” Destabilizing historical circumstances, periodic droughts, and postcolonial struggles for resource, e.g., oil in the Marra mountain region, add to the instability and violence.]

Deciphering the Voices of Genocide

In order to discern voice in relation to the experience of trauma in the war and genocide in Rwanda and the Great Lakes region in the mid to late 1990s.¹²¹ **[Deciphering the Voices]** Reinhild Kauenhoven Janzen and I spent several months in late 1994 to early 1995 doing interviews, analysis, and writing for one of the 150 NGOs at work in Rwanda, Burundi, and Eastern Congo.¹²² Although this was a most unusual

¹²¹ This topic was first explored in my lecture “Deciphering the Emotional Register of Trauma: An Anthropological Reading of War Stories from Rwanda and Burundi,” February 17, 2000, Case Western Reserve University, Department of Anthropology, Lectures in International Health Series.

¹²² We worked with the Mennonite Central Committee, which distributed Canadian Food Bank grain to Quaker communities in Burundi, vegetable seeds in Rwanda, and for about 9 months, supplied food, blankets, and medicines to four small Rwandan refugee camps in Congolese communities southwest of Bukavu. All this work was accompanied by extensive counselling and coordination work. We were asked to interview, write, and analyze the whole situation. Our ethnographic overview and the analysis is contained in: John M. Janzen & Reinhild Kauenhoven Janzen, ‘*Do I still have a life?*’ *Voices from the*

anthropological assignment, our coordinators and many of our interlocuters understood us to be approximately what we were: American academics, an anthropologist and an art historian, engaged to understand what had happened. They welcomed this effort, which usually affirmed their own desire to learn what had happened with the following two most frequently repeated pleas: “Please tell the world what you saw” and “be honest in your accounting.”

Yet, is it ever possible to grasp the depth of genocidal violence, or to maintain immediacy to it in a scholarly gathering such as this comfortable setting? In our listening we heard the words, the stories, of family survivors of genocide, words of those who had fled to a neighboring country, words of family members who had been away during “the events” and had come to the rescue of survivors; and, we heard the words of perpetrators of the violence.

My interest here in “reading the signs” is the tone, the emotional “register” of the voices, and the link between the heard voice and the events, experiences, and memories to which they refer, as an index of the nature of the trauma.¹²³ This “semiotic challenge” was prompted by hearing voice tones that were different than the predictable flat, affectless tone of those who had experienced terrible trauma and loss. Other emotions we heard included agitation, rage, yes, euphoria, and strange mixes of emotional tones that perplexed us. This project is really a continuing exploration of the thesis that such a range of emotional tone may signal varied experiences of trauma, and predict varied types of actions by these persons. It is an inquiry in process.

Let us meet a few of the people in the story, and consider their voices. I apply an anthropologist’s perspective of locality to the massive Rwandan war and genocide by concentrating mainly on the people of the commune of Kayenzi, west of Kigali. We decided to visit this commune after we learned that a number of families and individuals in one of the Congolese camps near Bukavu where we worked had fled from there. In this contextualization of the massive war and genocide we discovered the differential “emotional-moral” impact and involvement in the conflict.” Each of such “emotional-moral profiles”¹²⁴ had a different sequel-- in healing or continuing the cycle of vengeance and violence.

Ibrahim [**Ibrahim**], who described himself a Tutsi peasant, whose family experienced many deaths, survived himself because, when in the clutches of the assassins, he threw himself into the refuse pit just before he was to be executed.¹²⁵ He was rescued 10 days

Aftermath of War in Rwanda and Burundi. Lawrence KS: University of Kansas Monograph in Anthropology # 20, 2002.

¹²³ E. Valentine Daniel, in his research of Sri Lankan victims of the Tamil-Sinhalese civil war examines the invisible scars or memories of victims of torture, which, because invisible, are also difficult to talk about. Yet the victims are only able to come to terms with them once they have been shared, acknowledged, related to others. Daniel’s *Charred Lullabies: Chapters in an Anthropography of Violence*, 1996, uses a semiotic perspective to good advantage in analyzing the many dimensions of trauma and the signifiatory relationship of these hidden scars of violence to embodied memory and narrative.

¹²⁴ “Text and context in the Anthropology of War Trauma: The African Great Lakes Region, 1993-1995” *Suomen Antropologi: The Journal of the Finnish Anthropological Society*, 24 (1999)/4, pp. 37-57.

¹²⁵ *Life*, “Ten Days in the Pit,” pp. 71-72.

later by his Hutu godfather and mentor in Islam. Threatened again in the hospital, he was taken to a safe hiding place by this man, and thus survived and recovered. Later, he would encounter his persecutors, and, when asked if they admitted their deed, he forgave them because of his faith. Thus, with this process behind him, his account was amazingly even tempered, although his narrative voice became flat at times when he described his ordeal in the pit. Yet he was able to verbally express anger at the potential for man's inhumanity to man.

Damien, Tutsi Catholic, and teacher before the war, was appointed mayor of Kayenzi by the RPF government immediately after the war.¹²⁶ In his account, excerpts of which follow, his tone was totally flat and affectless. **[mayor of Kayenzi]**

"My mother, my father, 3 brothers and 2 sisters, 6 paternal uncles and their entire families—a total of 130 individuals—were killed. Myself, my wife and children, and one grand-niece were all who survived in our lineage. The genocide was nearly accomplished."

Three times assailants came to his door to kill him and his family, and three times he bribed them—people known to him—or persuaded them to desist. Once his little daughter's look of fear persuaded an Interhamwe militiaman to leave. When we visited with Damien, he was preoccupied with the Salvation Army's representative and the delivery of large plastic sheeting to line the mass grave for the reburial of the dead in Kayenzi, and with the numbers of people in his own jurisdiction (23 at the time of our visit, many more by later counts) were being arrested and brought to prison for eventual hearings in a paralyzed judicial structure that was just beginning to be recreated. At no time in our visit he was physically tense and suffering from malaria. The only note of relief he shared with us was the "healing" he had experienced from the return from Congo of his dear neighbors, a Hutu couple who had been fellow secondary school teachers.

Sixteen year old Carin was the oldest of three Tutsi girls whose parents were killed by genocidaires in Kayenzi. **[Carin & Josephine]** Their mother's friend, Josephine, rescued the girls and protected them by bribing militiamen.¹²⁷ Later, Josephine and her husband fled with the girls for the French protected Zone Turquoise. Despite the ordeal, Josephine's narrative was startlingly ebullient. She exuded confidence and good will, exalting and praising God that she had been given the courage to stand up to the madness of the genocide and had been able to rescue the three girls and become their mother.

[I rejoice] that I have saved the young girls and that I see them before me... the grace of God gives me joy, I want to sing all the time that He has wrought miracles during the war."

Josephine's account and her open, joyous, demeanor struck us as unusual. Coming so close to the flat narrative of Damien we began to pay closer attention to the tone of voice. At first puzzled by the disconnect of voice to the content of the story, we began, when we heard a tone of voice that we could associate with terrible hurt, anger, and fear, to become drained after several such testimonies in one day.

¹²⁶ *Life*, "War Erupts in Kayenzi, pp. 70-71.

¹²⁷ *Life*, "Flight to the Zone Turquoise," pp. 72-77, & 79.

The stories we heard in the camps [**Camp I**] of Kivu, Eastern Congo, like those inside Rwanda, recounted the beginning of the war, the invasion of home community and personal space, flight, chaos, loss of loved ones, and the misery of the camps, and continuing anxiety over where this would all lead.

[**Mathieu & family**] Mathieu and his family and associates, of Kayenzi, spoke in a controlled voice, but that was sometimes accompanied by a sense of foreboding.¹²⁸

[**Emmanuel**] Emmanuel, a government social service administrator in Rwanda up until the year before the war, fled with his family. His wife died on the flight. He was engaged as the head of the refugee committee that oversaw the four small camps northwest of Bukavu.¹²⁹ His account was full of dismay, disillusionment in the “Hutu” revolution, and foreboding over the future. He asked for help in seeking a way to find political asylum in a third country. The voice in his account was most self-controlled, not flat. But at no time did he smile or lighten up at all.

Laurent, the governor of Gikongoro, resided in a small camp with some of his administrators.¹³⁰ [**Eastern Congo, Camp II**] [**Laurent, Governor**] They had fled in government and personal vehicles, which remained parked around the large house that had served as a Baptist Mission post. As the highest ranking official in the camp, he lived in the house, and it was where he held court. In effect, this was part of the government in exile. Our first meeting was in this house. When I received a response of five individuals to my invitation to speak with “Rwandan administrators” I did not know what to expect. But they were above all eager to tell me, the American professor, their side of the story and to persuade me of the rightness of their cause. I opened the first of three such “focus group” sessions with the simple question “what happened?” By the end of the first session I began to experience the dizziness of extreme cognitive dissonance. I came away thinking that these men believed the stories they were telling me—about the Tutsi conspiracies, plots and weapons caches in churches, the conspiracy of the “international community” to destroy the Hutu, and the far greater genocide against the Hutu over the years than the alleged “Tutsi genocide” perpetrated by the recent government, which was “just a war” for which the Tutsi were responsible. The governor spoke in mostly controlled, very erudite, tones, with great experience, full of proverbs, in command of history. Yes, there had been killing, but it was a war, and the government needed to defend itself. Only later did I learn that he was one of the big plotters in Gikongoro, and that the massacres had been more systematic there than elsewhere.

Bugingo, whose memorable question “do I still have a life?” became the title of our book, was the most interesting of our Rwandan contacts, at any rate the one with whom we had the most extensive contacts.¹³¹ [**Memories of Bugingo...**] Bugingo’s life is a veritable saga with many emotional highs and lows, almost impossible to summarize. Expelled

¹²⁸ *Life*, pp. 336-37, “To Return Home or Not to Return Home.”

¹²⁹ *Life*, pp. 59-60, “Who Speaks for the Refugees?”

¹³⁰ *Life*, pp. 54-58, “Conversations with Refugee Rwandan Administrators.”

¹³¹ *Life*, pp. 21-35., “‘Do I still have a life?’ One Terrified Man’s Search for Repatriation.”

from army for insubordination by corrupt officials a year before the war and genocide, he was terrified that those who knew him would seek to destroy him. Thrice nearly killed, he finally fled to Congo, only to again find himself surrounded by those he feared, as well as terrified of returning. When he first sought us out, he was a bundle of jangled nerves, terrified of what awaited him, agitated as he told his story, and often breaking down in uncontrollable sobbing. Much later, as he wrote lengthy letters to various agency heads to secure safe passage home (and sharing these with me), we learned that he had indeed succumbed to “the dirty work” in Butare, where, threatened by militia, he had stood at a barricade where fleeing Tutsi and regime enemies were detained. Bugingo’s voice—agitated, paranoid, sobbing—in Bukavu we eventually understood to reflect the deeply conflicted emotions of one who had both been threatened, faced by death, and who had succumbed and participated in the killing against his will, to save his own life.

His own words in a letter of 2000, after emerging from the second prison term, explain the course toward healing best.

... sorry for the very long period spent without any informations and greetings... it is du to the fact that any freedom from prison was not all I need, as long as my mind kept on living a somehow captivity, my body watched and I am morally broken. I spent the most of my time in physical training and medicine consumption... I expect the Lord to perform a healing and to grant a social resettlement help...

He remained paralyzed as long as his mind was in “some kind of captivity.” His body was disengaged, and he was morally broken. A man of great resilience, he, the military trainee of a Korean karate team, a former sports instructor, takes up physical training as a therapy, along with unspecified medications. He also prays that he will be healed spiritually. Finally, he wishes to move from his rural commune where he feels stifled and defeated in terms of his youthful middle class and professional aspirations. But at least he is alive, having survived the threats of a corrupt army, three brushes with death during the genocide, the refugee situation in Congo, and two imprisonments in Rwanda.¹³²

Many communities in Rwanda have entered new phases of grieving, [**Remembrance: Our Dead are not Dead**] honor, and remembering their dead, often, as in Kayenzi, with mass re-burials. For some this lays to rest the terrible past, with a reminder that it will “never happen again.” For others, the remembrance [**Remembrance: Military observe pile of skulls**] may be a call to avenge the deaths of their kin, or fellow countrymen. In Burundi the memorializing mass grave of the Tutsi students burned in the petrol station bears the words “genocide” in order to associate it with what happened in Rwanda the following year. [**Remembrance, Kibimba**].

Above: Kibimba petrol station ruin in which Tutsi students from Kibimba Secondary School were doused in gasoline and burned alive following assassination of President Ndadaye in October, 1993 by enraged Hutu.

Below: Mass grave and memorial to "victims of genocide, 21 October 1993" for the Tutsi students of Kibimba.

¹³² Bugingo’s case needs to be seen as one of at least a million Rwandans who returned from flight and exile, of whom tens of thousands experienced temporary imprisonment. His story, part of a more massive movement of people who return home, is presented in my essay “Illusions of Home: The Story of Return of a Rwandan Refugee” in *Coming Home? Refugees who Return*, Pennsylvania, 2003, Eds. Lynellyn Long & Ellen Oxfeld;

“Reading the signs” in these narratives of war and trauma has been a great education in listening and learning of the drastically different courses each individual’s life took in those momentous days, hours, minutes, and seconds, those moments of truth. Each of the emotional-moral courses, as seen in the cases presented, plays itself out in a unique way: the survivor seeking reconciliation with a perpetrator, the survivor becoming public servant in the restoration of justice and order, the privileged category person who risks her life to save the victim category person, and feels great moral vindication and joy; the fear-paralyzed family head, unable to come to a decision to return home, perishes with his family in further rounds of fighting and reprisal; the perpetrators, in exile, dissimulate before the anthropologist, perhaps even believing their lies and justifications, living to perish in further fighting; finally, the hapless one who combines the fate of victim with that of perpetrator, presenting the most turbulent emotional-moral profile of all, but this particular individual somehow survives to see a new day. “Reading the signs” here also entails bringing together into one framework the diverse dimensions of the political, social, familial, and individual body, mind, and memory.¹³³ Our own learning began with hearing the eerie disjuncture between some persons’ stories and the tone of their voices, realizing our own emotional threshold of being able to listen to only a few of these stories in a given day. It was like visiting Russia and hearing everyone and every family’s Gulag story, yet discovering that not everyone was equally affected, or similarly traumatized, or that people were traumatized differently.

Anthropological Findings?

- [Political context defines identity-shaping course of events and the subsequent construction of a useable memory
- Differential trauma, may be reflected in the “emotional-moral profile” of individuals in a community
- The impulse to vengeance is widespread after violence and trauma, but it may be assuaged in a number of ritual-religions, social, and juridical ways
- A minority may polarize an entire society wreaking great havoc
- Formulaic generalizations about entire countries, ethnicities, and communities, are usually forced and wrong
- The construction of memory and commemoration of traumatic events are important in overcoming collective trauma

Conclusion

Each of these projects in reading the signs of sickness and healing has stressed the importance of social context; of evolving traditions that are sometimes eclipsed by

¹³³ Arthur Kleinman’s work on Chinese victims of the Cultural Revolution shows the scope of analysis that is required to understand the full context of trauma memory. See his “Suffering and its professional transformation: Toward an ethnography of interpersonal experience” (pp. 95-119) with Joan Kleinman, and other essays on trauma, in *Writing at the Margin: Discourse between Anthropology and Medicine*, 1995. Mariane Ferme has recently examined the relationship of ambiguities of everyday life and eruptions of violence in *The Underneath of Things: Violence, History, and the Everyday in Sierra Leone*, 2001.

momentous and cataclysmic events yet often seem to re-emerge in new guise. They have also abundantly given evidence of the embodied transformation of suffering in the course of time, from raw anguish, to naming the affliction, to stages of response, and finally to controlled routinization or cultural incorporation of the affliction. We have seen the elusiveness of words, and amidst the importance of narrative, the use of all points of on the sign continuum. An especially persistent theme in these instances of African healing has been the embrace of marginality, its embrace as a source of power and authority. The “wounded healer,” the “healed leader,” or the “healed sufferer-doctor” are steps toward the more inclusive theme of the healing of society.

An anthropological optic of these experiences and phenomena must be “connect the dots” of broad political forces as well as individual experience, the verbalized ideas and concepts of testimonies, documents, speeches, and interviews, while at the same time knowing and appreciating the embodied, ritualized, life of persons in the process of finding wholeness.

IV. The Social Reproduction of Health

Chapter 11

CARE-GIVING, THERAPY MANAGEMENT, AND POWER IN WESTERN EQUATORIAL AFRICAN HEALING ¹³⁴

The ability to heal, the knowledge of therapeutic techniques and health solutions, caregiving, any wherewithal to health from whatever source, constitute intrinsic powers that have been compared to other "raw" materials such as foodstuffs, fire, earth, water, air. They are transformed through domestication, they are given meaning, classified, controlled, or at least coordinated, and also exploited for gain; they are converted into wealth, status, and political influence. Michel Foucault's view that knowledge is power,¹³⁵ just as sex and madness have a kind of power, is critical to the understanding of the "raw power" of caregiving, healing and medicine. For Paul Unschuld, the "primary resources" of medicine and healing --the skills of healers, the medicines, the knowledge -- become "secondary resources" as they are researched, licensed, institutionalized, commercialized, and otherwise given shape by society.¹³⁶

Africa is a huge continent, and a topic as complex as care giving to sick individuals can hardly be made on so vast a scale. Even a focus on a geographical region such as Sub-Saharan Africa is comparable to generalizations such as "North America," including Eskimos, New Yorkers, and Panamanians. This focus on Western Equatorial Africa—centered on the Kongo region of northern Angola, Western Democratic Republic of Congo, and southwestern Congo—recognizes common sociocultural features such as strong unilineal descent groups, undeveloped state health care services, virtually no medical insurance, in the face of strong traditional and biomedical healthcare services. These are societies that have experienced colonial occupations destructive to earlier professional structures, and postcolonial eras that have seen civil war and crumbling infrastructures. Constellations of kin, friends, and professionals take charge of the sick and dependent, provide care, seek help, and make decisions about the course of treatment.¹³⁷ In this region there are also historic and contemporary examples of

¹³⁴ Earlier versions of this chapter have been presented at the University of Pennsylvania Barbara Bates Center for the Study of the History of Nursing (Spring 2007 Colloquium on the History of Caregiving), at the Medical University of Vienna (Spring 2004) lecture on "Resources", and from a reconsideration of therapy management in Chapter 7 of *The Social Fabric of Health: An Introduction to Medical Anthropology*.

¹³⁵ M. Foucault, *Power/Knowledge*, New York, Pantheon, 1980a; *The history of sexuality*. New York: Vintage/Random House, 1980b.

¹³⁶ Unschuld, "Medico-cultural conflicts in Asian settings," *Social Science & Medicine*, 9(1975), 303-312.

¹³⁷ This work was summarized and updated in my 1987 article "Therapy Management: Concept, Reality, Process" in *Medical Anthropology Quarterly* 1:1(ns), pp. 68-84, as well as reviews and suggestions for further research in the topic. In the past decade, the perspective for research on health care seeking and decision-making has been widely followed, especially in Sub-Saharan Africa where state institutional health care is collapsed or weak. A few examples include: Steven Wolputte, et. al., *Medical Pluralism and Lay Therapy Management in Kinshasa*. Uppsala, 2001; Gabriela Koerling, *Lahiye vitesse and the Quest for Relief: A Study of Medical Pluralism among the Saga of Niamey, Niger*, 2005; Sjaak van der Geest, a

specialized healing networks or cults in which a permanent support community is made up of the formerly afflicted, some of whom have become acknowledged healers.¹³⁸ Medical traditions are endlessly negotiated and recreated, as are the conditions of life and health. Life circumstances are often fluid and flexible, subject to change and opportunity. Yet in this process it is possible to see how medical "traditions" are manifested, how the primary resources are controlled and coordinated through decision-making by practitioners and clients; how techniques, practitioners, and bodies of knowledge are given authority, that is made legitimate; how they are incorporated as groups and institutions; how practitioners organize as professionals; how sovereign states further organize and lay claim to controls of medicine and healing, or encourage the agents of the market to use medicine to make wealth; and, how we may interpret the shape of medicine that results from such political control, or lack thereof. Without such control, sponsorship, legitimation, or organization within institutions, the power of medicine and of healers is often seen as dangerous to others, and is associated with witchcraft, sorcery, or evil that is threatening to ordinary humans, or, in the contemporary setting is seen by critics as excessive "medicalization."

The care-giving paradox in Central Africa

Africa has long caught the world's attention for its heavy load of sickness and misery. Yet many have failed to notice the highly developed institutions of care that—perhaps unsurprisingly—accompany this history of sickness. Research on African caregiving has been sporadic, but it should come as no surprise that primary care givers are indeed family and kin. A few examples of such research suffice to make the general case. In a recent research report on care for at the end of life for 2.5 million HIV/AIDS sufferers, and the .5 cancer sufferers in five African countries—Botswana, Ethiopia, Tanzania, Uganda, and Zimbabwe—92% of caregivers were family members.¹³⁹ The concern of the research was the burden of caring who die annually in Africa. The WHO project sought to create palliative care centers that could ease the burden of family care givers, and provide pain relief. Elsewhere, in the studies of outbreaks of the deadly Ebola virus, the prevalence of close proximity caregivers to the infected and dying illustrated the strong tradition of care giving, but as a problem. Touching [**woman seated with cadaver**], bathing, comforting at close proximity to the infected, needed to be broken to end most epidemics. [**cartoon drawings of risky customary behaviors**] Only strictly enforced regimes of quarantine could break the spread of infection. [**quarantine fences & tent**] The difficulty by public health officials to impose quarantine gives evidence, however tragically, to the strength of caregiving practices in Central Africa.

project on therapy management culture in a 2005 Kenyan hospital ethnography project proposal; Bernhard Bierlich, *The Problem of Money: African Agency & Western Medicine in Northern Ghana*, 2007;

¹³⁸ See my *Ngoma: Discourses of Healing in Central and Southern Africa*, California, 1992, which focuses on four regional clusters of such cults of affliction: Kinshasa and Western Equatorial Africa; Dar es Salaam and East Africa; Capetown, Mbabane, and Southern Africa. Throughout this vast region "ngoma" means "drum of affliction."

¹³⁹ Cecilia Sepulveda, Vincent Habiyambere, Jacinto Amandua, Margaret Borok, Ekie Kikule, Barbara Mudanga, Twalib Ngoma, and Bogale Solomon. "Quality care at the end of life in Africa." *British Medical Journal*. 2003 July 26; 327(7408): 209–213. www.pubmedcentral.nih.gov/articlerender.

These illustrations of Central African care-giving from the horror columns of HIV/AIDS, Ebola and cancer cases do not do justice to the rich and powerful tradition of care-giving that has evolved in relatively more benign circumstances of sickness, both episodic and chronic. I first offer anecdotal examples of care-giving that I have witnessed, and then provide a systematically researched case-study from the Quest for Therapy in Lower Zaire to illustrate the structure of care in the accompaniment of diagnosis, decision-making, and therapeutic directives within the mantle of therapy management and the therapy management group.

A review of my field notes in search of instances of care-giving as defined by the organizers of the Bates Center for the History of Nursing Colloquium reveals that I was so exclusive in my search for structures, decision-making procedures, and therapeutic content that I ignored care-giving as a feature in its own right. I grew up with nurses all around me (my mother, my sister, my mother-in-law). The nurse-anthropologists¹⁴⁰ I have advised through to their PhD degrees have reminded me that anthropology's regard of humans and the human condition was too impersonal, heartless, and cold. I stand chastised for my myopic blinders that imposed a hyper-rationalist perspective of decision-making, resource analysis, and linearity while ignoring touching, caring, comforting, feeding and accompanying.

Upon re-examination of my notes, photos, and films I find the following.

¹⁴⁰ These include Lois Rimmer (former director of nursing program, Washburn University), Ann Cobb (professor of nursing, University of Kansas Medical Center), Linda Redford (PhD researcher, KUMC), Jennifer Hunter (Professor of Nursing, University of Missouri, Kansas City), Kirstin Lundberg (PhD student). Jennifer Hunter offered a check list of themes in caregiving as seen in nursing. Depending on their background, she wrote, "nurses ...may or may not "speak" social science language. They may think in terms of health care system(s), professional and home 'caregivers,' assume that the ill person is the decision maker re: his or her illness and treatment (individual autonomy), and that the sick individual is the main focus for the decisions. Health sciences embody aspects of both constructivism and positivism, but many nurses are trained mostly in a positivist manner, and you may need to explain through example how health, illness, decision-making, personhood etc. are socially/culturally constructed." ... Her list of topics that would compare across cultures was: (1) Who makes care decisions (that can lead right into your therapy managing groups)? (2) Who gives hands-on care? Are these persons involved in any decision making? What is the priority sequence of seeking help from caregivers - family, "traditional" healers, Western medicine, and why? (3) What underlies decisions regarding sick care for an individual? Is it what is best for the sick individual, or what is best considering overall resources for the household/community? Is it influenced by age, type of illness, etc. in specific ways? i.e. productivity of the very young and very old, vs. a very productive young to middle age person? (4) How are the sociocultural construction of ends of personhood reflected in caregiving decisions? Or when is an elderly or chronically ill person socially dead and nonproductive, vs. physically dead? (5) Where does the concept of NURSING, as we think of it in the US fit into the caregiver continuum? (Continuum of caregivers, such as family caregivers in the home, lay people outside the home who help, socially defined healers /midwives / spiritualists / vegetalistas...outside the Western medical system, and those within Western health care system) (6) How has a nurse role evolved? (7) What are the duties of the role? (8) What gender typically fills the role? (9) What is the role named? What power or sense of service is denoted in the name? (10) What are motivations for the role (\$, religion, status); (11) What training is involved to assume the role? (12) How has professionalization occurred for the role? (13) How has Westernization occurred within the role? (14) What power, oppression, status is involved in various stages of the "nurse role," if one exists? Is it gender related?

- Wife of palm nut cutter who fell and sustained a triple fracture, remained at his side for weeks during his care and rehabilitation at a traditional orthopedist's compound; she attended to his needs during the daily painful massages of the orthopedist; she gave him water to drink in the midst of the painful hour-long treatment of his fractures and wounds; **[from videofilm, Zablou, nganga lunga]**
- Aunt of woman suffering from mental anguish, accompanies her to visit a distant healer, a dispensary, and another healer; **[Nzita, Quest]**
- Parents accompany young professional to the compound of a diviner-prophet to diagnose his continuing sickness and to seek respite in a retreat;
- Brothers take their sister to a series of clinics, hospitals, and healers in search of relief for physical symptoms accompanying unresolved matrimonial relations.
- In large hospitals, family caregiving is shared with staff—nursing, and nurse-aid—care, as can be seen in this ward at Kimpese hospital in Lower Congo; **[Kimpese view]; [Mangembo view]**
- Personal care from kin in mass hospital ward alongside professional nurse **[Kimpese, Quest]**
- Professional nurses offer the same kind of care and attention as is given in the Western world, as is seen here in a receiving ward of a clinic, on children's day; **[Quest]**

“A History of Madness”: Caregiving and Therapy Management in Kongo society

Of all the cases that were published in *The Quest for Therapy in Lower Zaire*, that of Nzita Ann in “A History of Madness” is perhaps the most relevant to the Caregiving Colloquium and to conditions in Congo thirty years later.¹⁴¹ Nzita is an urban woman trying to raise five children on a husband's insufficient salary as a doorman. Like many of her country peers decades later she seeks refuge in a Christian independent church, where she has an affair with a “prophet.” Guilt and depression consume her, and she begins to lapse into episodes of incoherence and destruction of household property. **[episodes shown from Quest]** In characteristic Kongo behavior, her husband and other kin take her to a diviner-counsellor who listens to her story and recommends multiple treatments—herbal treatment from nganga, hospitalization, medication. Eventually her husband with the advice of other kin decide to escort her to home to the village where the maternal kin (of which she is a primary member) recommend another diviner, and another meeting of the full clan for mutual confessions. The maternal kin are now torn between an indigenous course of therapy with a recognized treatment for

¹⁴¹ “A History of Madness,” Ch. 5, *The Quest for Therapy in Lower Zaire*, pp. 81-89. It follows “Disease of God, Disease of Man” (a case that features the Central African ambiguity of etiology and personhood), “Strife in the Family as Cause of Child's Illness” (on the role of conflict in pushing causal attribution into the human realm). “The Professional as Kinsman” demonstrates that even a biomedically trained nurse when afflicted is subjected to the same forces of social reasoning as anyone else; “Marriage and the Father's Blessing” continues the inquiry into social issues that affect diagnosis and recommendation of appropriate therapy. The case studies conclude with “The Clan as Patient” that features a series of individual sicknesses that are deemed to have a single underlying corporate cause; the chapter shows some of the therapeutic strategies used to deal with them.

madness, and biomedical hospitalization. As it turns out, both courses are followed simultaneously. [**Nzita with Madeko, aunt watching**] From there Nzita is escorted and attended by a maternal aunt for an indefinite period of rest and work in the fields with her aunt, with periodic sessions of massage by another healer.

Therapy Management and Caregiving Professionals

The figure of the nurse was introduced to Western Equatorial African medicine through medical missions and their colonial regulators. Often the missions opened schools for nurses or medical assistants, who then helped European or American doctors and nurses. [**Kibunzi infirmiere graduates; midwife aides**] Protestant and Catholic missions competed for coverage of the territories of Western Equatorial Africa, both providing redundant services staffed by their national and religious version of the truth. Thus, in the Lower Congo north bank, the Manianga, the Swedish Covenant Church mission, the White Fathers had hospitals, dispensaries, and local outposts where their European and African personnel were stationed. Only after independence in 1960 did the state open hospitals and dispensaries. Even then, missions continued to be considered the better posts for medical care.

Yet as I have demonstrated in the case-studies of *Quest*, half a century of mission and government medicine did not cause African healing to disappear. The proliferation of different kinds of medicine, if anything, gave an impetus to the process of kin therapy management. Someone needed to sort through the competing and contradictory therapeutic claims and possibilities [**Therapy managers, decision-makers**] The therapy managers are parents and mother's brothers, those who hold general social rights over the sufferers, children, and matrilineal descendants (Kongo being a matrilineal society). Often the diagnosis of a case needs to be negotiated by these kin, and it is they, or a designated individual from among them, who accompanies the patient to a diviner, healer, hospital, or clinic. Only adult men tend to be "in charge" of their therapy seeking, and even they, when they become sick, cede decision-making authority to another kin figure. Because of the kin therapy managers' control of the process of therapy-seeking, payment or reimbursement is not made to a healer until the therapy has been deemed successful and effective. Much to the consternation of the medical personnel in Western-oriented clinics and hospitals, patients under the guidance of a kin therapy manager may also be taken from the wards for alternative treatment at an African medicine doctor without the consent of the attending staff. A close ethnographic coverage of case studies revealed a pattern of "shuttling" between types of therapies. [**The course of therapy, Quest fig. 17**] ¹⁴²

¹⁴² Medical anthropologists have used a range of terms to describe and analyze what I have called the "quest for therapy." Marc Auge and colleagues have used the phrase "itineraire therapeutique" to describe the "totality of processes involved with their detours and curves in a quest for therapy, going from the appearance of a problem to all its steps, institutional or not, where diverse interpretations may be identified (divination, rumors) as well as cures, in a pluralistic medical context (Nicole Sindzingre, in "Presentation: Tradition et biomedicine," *Sciences sociales et sante*,

The therapy managing group is constituted of those who participate in the diagnosis, decision-making, and care of a patient (or related group of patients). This always includes someone or some social group who is sick (for households, lineages, entire communities may be considered "sick"). It normally includes a next of kin. But at the time of uncertainty and crisis within the kin community, it also includes the diviner who is consulted. It may also include, for each episode or string of related episodes, appropriate healers or medical personnel, including Biomedical practitioners (who are usually unaware of the structure of the therapy managing group). Nurses therefore tend to be involved in caregiving mainly within the confines of institutions: clinics, hospitals. And even here, their care is often brokered through or at the behest of the lay therapy managers.

Yet nurses in Western-type medical institutions have other sources of authority and power that have both derived from their control of resources within the institutions, as well as from recognition in society at large that with their power to heal they are powerful in their own right.

Nurses' Power in Institutions and Society

In the postcolonial context the nurse emerges as a more powerful figure, especially in those all too common situations there is no doctor present, or the supervising doctor is distant and visits only intermittently. Soeur Emelie at Mangembo Catholic Hospital [see **videofilm segment**] had only a nurse's training, but when in 1960 the large hospital required a director, she filled the very large shoes of the last Belgian medical doctor who abandoned the region. Sister Emily proved quite capable of running her large staff and meeting and caring for the scores of people who arrived daily for care. Nearby, at the Protestant dispensary of Sundi Lutete, the African nurse who had served under many missionary nurses and distantly supervised by a doctor, continued to be the steady presence and authority. [**Kayuma as lineage head**] His role as head of a large lineage nearby, and his experience with kinship politics, led to him resorting to the power politics of the *nkisi* (magical charm, spirit-rooted rhetorical threats) in decision making and struggles for power within the mission structure. The

3, 3-4, 1985, p. 14). "Therapy seeking" or "health seeking" have been used recently to describe this practice. Decision-making models have been used for a wide range of studies of how the knowledge and reality of illness experience shapes care-seeking and care-giving. In recent years however anthropologists have shied away from exclusive emphasis on rationalistic decision-making or formalistic aspects of these decisions. Thus the "hierarchy of resort" introduced several decades ago suggests too rigid a construct for the open-ended and sometimes contradictory directions taken by Equatorial African therapy managers (see Lola Romannuci-Ross, "Hierarchy of resort in curative practices: The Admiralty Islands, Melanesia," *J. of Health and Social Behavior* 10 (1969), 10, pp. 201-209). Anthropologists have come to emphasize both the wider political and economic realities in shaping medicine, as well as the emotional dimensions of the experience of suffering and undertaking healing.

threat of being replaced by a better trained younger nurse occasioned the senior nurse's use of African medicine.¹⁴³

Elsewhere in Central Africa, the **figure of the nurse** has evoked other images. Lynn Schumaker has studied the Zambian Kalela dancers, or Beni Ngoma,¹⁴⁴ a generalized cult of affliction and modernizing dance that reached the Copper Belt from the Swahili coast in the 1960s, portrayed a variety of urban and European emulating roles in its repertoire of dances and songs. One of these was the doctor/nurse dyad, a powerful trope that not only served to entertain, in a range of performance settings, including competitive sports. The figure of the nurse in these dance performances quickly evolved into more than just an emulation of hygiene-teaching and –practicing professionals. The emphasis on hygiene soon expanded into the advocacy of social purity, and the pursuit of witch-finding rituals. Nurses could hold mirrors up to the faces of a crowd and detect the witches in their midst. The promotion of hygiene here morphed into witch eradication. Thus, the westernization of African medicine and the Africanization of health professionals are both an integral part of the scene of caregiving in this part of Africa.

Power and Legitimacy in Medical Resource Control

Although the thematic, cultural, element, or core idea approaches just summarized are good at identifying the basic intellectual coherence of a medical tradition, they tend to ignore the significant economic, political, and ideological underpinnings that often are put into health and healing by society. These vested interests and pressures certainly help determine which ideas, techniques, and practitioner types will become dominant or become marginalized, which will become the leaders and which will become socially invisible, or even illegal. Medical anthropologists and related analysts have put forward a number of perspectives to identify the ways in which vested interests--political, economic, ideological--affect medical practices and ideas. These issues have been addressed by medical anthropologists at both the large-scale level of national or global institutions, as well as at the very small-scale, intimate, level of clinical decision-making and the social processes around individual cases. The first has been called "macro-analysis," the second "micro-analysis." But the issues are really the same.

Although there are many lines of analysis of the political and economic shaping of medicine, that which has been referred to as the "resource model" is helpful here.¹⁴⁵ As primary medical resources--i.e., medical knowledge, materia medica, and the skills and techniques practitioners used to address health needs--are controlled and coordinated, they translate into secondary medical resources of

¹⁴³ See *Quest*, Chapter 6, "The Professional as Kinsman." Pp. 90-100.

¹⁴⁴ Lyn Schumaker, "The dancing nurse: kalela drums and the history of hygiene in Africa." Penelope Gouk, ed., *Musical Healing in Cultural Contexts*. London: Ashgate, 2000, pp. 149-170.

¹⁴⁵ Unschuld 1975, 1992; Crandan-Malamud 1985.

economic and political influence, the infrastructure of professions, of salaries, of clientele, of institutions. Unschuld originally developed this scheme in his study of dynastic China where he noted the ways in which the kingdom both enabled and controlled the practitioners of Chinese medicine. Later he would apply it to the twentieth century setting of competing medicines in China. In dynastic China, some paradigms of medicine and their respective practitioners were given the backing of the court, whereas other types of medicine, particularly shamanism, were repressed, or at least driven to the margins of kingdom society. One of the central tools that court physicians used to gain their control over the practice of medicine in the wider society was a code of medical ethics. With this, the medical elite of dynastic China was able to sanction all opponents by imposing its ethics upon a limited field of practitioners, and by forbidding access to all those who did not conform to their concept of ethical medical practice. Some of these issues of state and professional power and control of medicine will be taken up later in this chapter.

At the intimate scale of clinical decision-making, where practitioners and their clients meet, the interplay of primary and secondary resources also becomes very apparent. Medical anthropologists have studied the process of clinical decision-making to determine how knowledge, techniques, practitioner skills, and medicine are coordinated and controlled by the vested interests of patients, their families, professional groups, the forces of the market, and the state.

Other medical anthropologists have directed their interests a little more closely upon the social context of therapeutic decision-making, the negotiations of alternative or varying viewpoints, the process of decision-making and medical reality in a setting where there is not a dominant model with dominant professionals, rather multiple or pluralistic medical settings. Control of the "primary medical resources" may even be in the hands of non-healers. Such a medical setting was studied by this author in Kongo society of Central Africa (1978b), and is featured in the accompanying vignette. In such a setting of perhaps extreme decentralization of authority in society as the Kongo cases represent, the primary medical resources of knowledge, techniques, and materia medica are largely controlled by the same forces as control any resources of whatever type. Medicine is embedded within the structures of general society, in this case largely kin-based. Healing is often subject to the conflicts and limits of other resources such as land, food, and precious and desired states of being, within the same social institutions as govern all other social processes. It becomes a situation of "struggle for control" of the primary resources, as another medical anthropology and history scholar of East Africa has noted.¹⁴⁶

Anthropologists and other social scientists have long made the point that much power, that is control, is exercised with the consent of the controlled. Some writers make the distinction between **power**, the sheer ability of some to manipulate others or to control them, and **authority**, the consensual exercise of

¹⁴⁶ Feierman 1985: 82-83.

power in a legitimate manner. This distinction is helpful in an understanding of how the resources of health and healing may become the focus of tremendous influence in society, both by those who have or are reputed to have skills of healing, and those who manage somehow to transform those skills into influence, wealth, and fame, or to control others with such skills. Related to this is the process by which medical paradigms and the institutions and practitioners who represent them, are accepted by the public. Thus the authority of medicine in Western industrial societies may be taken for granted because it is said to be based on scientific truth, it is conducted by certified, licensed practitioners, it is protected by professional codes of ethics, and it is regulated by state laws, all of which are supported by the public or professional groups. This has not been the case everywhere, nor for all times.

Chapter 12

THE SOCIAL REPRODUCTION OF HEALTH ¹⁴⁷

Over the course of several decades that I have been studying and writing about health and healing in Africa, I have sought to theorize the ways in which distinctive institutions, initiatives, and individuals have maintained, improved, and restored health where it has faltered. The juxtaposition of African social and healing approaches with Western introduced medicine has often resembled a conversation between speakers of languages that are barely mutually intelligible. I have rather sought to find and develop measures and models that might situate these incommensurable traditions within a single quest for health and healing. This search was begun in *The Quest for Therapy in Lower Zaire* (1978),¹⁴⁸ and it has continued ever since.

This essay summarizes the development of the “social reproduction of health,” first named as a theoretical perspective in *Ngoma: Discourses of Healing in Central and Southern Africa* (1992), the monograph that sought to make sense of a widespread type of healing termed “drums of affliction,” “cults of affliction,” or “ngoma” after the central role of drums in this ritualized self-help divination and healing of the commonly afflicted and possessed. The perspective of health embedded in social practices and institutions was reasserted in other research and writing, including *The Social Basis of Health and Healing in Africa* (1992), and *The Social Fabric of Health: An Introduction to Medical Anthropology* (2002).

In brief, this perspective holds that health—relatively better or relatively worse, by whatever criteria of definition—is socially produced and reproduced. Society’s resources are controlled by social classes and power centers, moved through institutions of greater or lesser scale, to meet perceived need, they are given meaning and symbolic definition, they are reproduced as society sustains patterns of care, healing, and well-being. Thus, to meet the minimal standard of the World Health Organization’s guidelines for health a society must have “adequate food, good water, housing, and safe living conditions” and to assure their continuous availability, a cushion of customs and social relationships must exist. By whatever definition, where part of society is decidedly less healthy than another, this hierarchical condition is a reflection of power and class relations, the control—or lack—of resources needed to enjoy good health. The “social reproduction of health,” combine the health definitions and terms of the society itself and outside evaluations with a society’s ability and on-going set of practices and potentials to define, maintain, or restore health where ill health or has occurred. After reviewing the origins of “social reproduction” theory and the addition of health to this perspective by

¹⁴⁷ This is an updated and revised version of an earlier essay published *Essays in Medical Anthropology / Festschrift –30 years of Austrian Ethnomedical Society*. Eds. Ruth Kutalek & Armin Prinz. Muenster, Berlin, Hamburg, London, Wien, Zurich: LIT-Verlag, 2008.

¹⁴⁸ Janzen, John M., *The Quest for Therapy in Lower Zaire*. Berkeley, Los Angeles: University of California Press, 1978.

anthropologists, I will return to four case studies from the African continent and draw some conclusions.

Social Reproduction in Classical Social Analysis

"Social reproduction" is a standard concept in the sociology of the modern world, and the social anthropology of the expansion of colonial and global capitalism. It is the notion that over time groups of people, notably social classes, reproduce their social structure and patterns, and that over a longer term, groups of people (and classes) act fairly deliberately to reproduce the existing social structure to preserve their advantage, generation to generation.¹⁴⁹ The social reproduction perspective was critical to Marxism and structural Marxism of the 1970s and 1980s, although it has outgrown those narrow theoretical formulations. Recently it has been applied to globalization studies and the manner in which huge gaps between haves and have-nots re-emerge in the world-wide shifting of capital, labor, commoditized goods, and how shifting services affect wider publics. The rights and privileges that nations once assured their citizens have seemed to come undone for many, especially children's rights, and the parents who face an increasingly desperate struggle on their behalf.¹⁵⁰

Anthropologists have contributed to the perspective of social reproduction either to conceptualize the impact of colonial capitalism upon far-flung societies of the world, or to understand current structures and impacts of globalization. Some anthropologists looked at these two conditions as separate in the societies they studied. Others saw the introduction of colonial capitalism and the commoditization that accompanied globalization co-mingled in the same societal structures. Africanists and Melanesianists used this perspective with good results to demonstrate how households, lineages, and local societies reproduced themselves through the maintenance of rituals, gift exchanges, and institutional domains that provided or reinforced local identity. One of the earliest anthropological uses of social reproduction was Pierre Bourdieu's generalized economic, symbolic, and biological account the Kabyle (of Algeria) lineage and how it maintained itself over time through strategies of resource control and marriage alliances. This insight was reformulated as the "habitus", the space within which all these resources converged to produce social and symbolic capital.¹⁵¹ When Bourdieu turned more exclusively to the study of modern industrial society, social reproduction came to require its corollary, "cultural reproduction" the way that education, media, the arts, religion, and communications assured the perpetuation of society's privileged, as well as marginalized.¹⁵² Colin Murray wrote about on Lesotho local societies caught up in labor

¹⁴⁹ Bilton, Tony, et. al. *Introductory Sociology*. London: MacMillan, 1996, 3rd edition, p. 670.

¹⁵⁰ Katz, Cindi. "Vagabond Capitalism and the Necessity of Social Reproduction." *Antipode*, 33 (2001), 5, 708-727.

¹⁵¹ Bourdieu, Pierre. *Outline to a Theory of Practice*. Cambridge: Cambridge University Press, 1977.

¹⁵² Bourdieu, Pierre and J-C Passeron. *Reproduction in Education, Society and Culture*. Beverly Hills: Russel Sage, 1977; Nash, Roy. "Bourdieu on Education, Social and Cultural Reproduction." *British Journal of Sociology of Education*, 11(1990), 4, pp. 531-447..

migration to the mines and factories of South Africa, and the way that investments into local rituals kept home communities and identities alive.¹⁵³

Claude Meillassoux articulated a formula for the social reproduction of the domestic realm in his economic anthropology of the Gourou peasantries in the Ivory Coast.¹⁵⁴ For a society to survive and persist, the newly-born and children, at a minimum, but usually also the dependent elderly and the sick and the handicapped, must be fed, cared for, clothed, and provided with their basic needs. For a society to survive, its productive members are required to produce adequate surplus resources—however these are defined—to take care of their own needs as well as the needs of the dependent young, elderly, and sick. Furthermore, there needed to be adequate institutionalized channels of redistribution over time from the productive members of society to the dependent ones, for a society to survive, that is to “socially reproduce” itself.¹⁵⁵ The scale and focus of such socially reproductive activity could be identified and the overall adequacy of a society's social reproduction could be determined—usually the household, a more inclusive family or kin group, the local community, or a network of some kind.

Robert Foster, a student of Melanesian society, identified two kinds of social reproduction in Tanga society, one based on “replication”, the other on “multiplication” of forms, practices, and resource use.¹⁵⁶ Replication occurred in mortuary rituals that honored the lineage dead, stimulated exchanges, and the performance of ceremonies. This type of social reproduction in effect “sealed off” a domain of culture that the Tangans recognized as *kastam* from more open-ended commercial transactions, that they came to call *bisnis*. However, some aspects of replication “condition transformations in the historical encounter with practices of commodity production and exchange. The contrast between replication and multiplication facilitates speculation about how the process of commoditization has taken different trajectories in different Melanesian societies.”¹⁵⁷ The exchanges of *kastam* that are found in mortuary rituals promote egalitarian relations, whereas the transactions of *bisnis* introduce commoditized hierarchical relations. Foster sees a disjunction emerging between the two types of reproduction, the one promoting identity, the other a valuation on money as a much sought after resource. “The pressures generated by multiplication continually to disburse (and disperse) valuables, ... makes money a much-sought-after resource. The deployment of money in exchange practices gives them a hybrid (even “postmodern”) appearance: money, trucks, and tradestore items circulate alongside of pigs and pearlshells.”¹⁵⁸

It appears that anthropologists have been most interested in social reproduction where it “seals off” a realm of culture from globalized commoditization, or shows such a realm in

¹⁵³ Murray, Colin. “The work of men, women and the ancestors: Social reproduction in the periphery of Southern Africa. In: Sandra Wallman (ed.) *The Social Anthropology of Work*. New York: Academic Press, 1981.

¹⁵⁴ Meillassoux, Claude. *L’anthropologie économique des Gourou en Côte d’Ivoire*. Paris: Mouton, 1964;

¹⁵⁵ Meillassoux, Claude. *Maidens, Meal, and Money: Capitalism and the Domestic Community*. Cambridge: Cambridge University Press, 1981.

¹⁵⁶ Foster, Robert J. *Social Reproduction and History in Melanesia: Mortuary Ritual, Gift Exchange, and Custom in the Tanga Islands*. Cambridge: Cambridge University Press, 1995

¹⁵⁷ Foster, Social Reproduction, p. 17.

¹⁵⁸ Foster, p. 18.

relation to globalization. Meillassoux, in *Maidens, Meal, and Money* points out that even the household in modern society includes many services, exchanges, and expenditures of time that are not recorded in the official economy, and therefore represent a kind of domestic ritual refuge from capitalist nation-state economics. Katz, writing recently about family and household in the shadow of a new, more rapacious "vagabond capitalism," suggests that ever increasing dimensions of the family and household are commoditized, requiring those who wish to cope with this situation to work ever long hours just to keep up.¹⁵⁹ It appears that this "sealed off" realm has been eroded to nothing, and has itself become a site of speculation and profit.

Adding "Health," "Ill-Health," and "Health Risk" to Social Reproduction

The explicit inclusion of health in social reproduction was done to identify a way to describe the efficacy of ritual healing in the sub-Saharan ngoma networks and cells. Meillassoux's formula for the reproduction of the domestic realm in particular seemed almost synonymous with health care and support: assuring that the productive adults paid attention to children's health, the care for and restoration of the sick and disabled, and the support of the post-productive elderly. I wrote in *Ngoma* that social reproduction "refers to the maintenance of a way of life and the commitment of resources to relationships, institutions, and support organizations that directly or indirectly maintain health".¹⁶⁰ Most Ngoma networks in Central Africa at least were focused around particular self-identified disability groups—women with reproductive troubles, parents of twins, troubled elite merchants fearful of their kinsmen's envy of their wealth, urban immigrants with diffuse troubles—that followed a typical format for the identification of their affliction-possession by a diviner, initiatory-therapy with a healer-master, counseling and ritual activity while in a novice state, and eventual "graduation" to healer status or continuing semi-chronic suffering of the condition. In *Ngoma* and elsewhere I tried to show how social reproduction was grounded in network building and resource reallocation among the commonly afflicted and marginalized. The resources marshaled for the marginalized sick included the diagnostic ideas and knowledge held by the healers, the self-generated therapies around their afflictions, and the social networks within the community of sufferers and healers, and from them to society at large. "Wounded healers" emerged from the ranks of the sick, to reach out to others similarly wounded. This network model thrives in stateless segmentary societies, and in societies with weak states or in social sectors at the periphery of state societies, and in contemporary urban settings. Where states are at the center of addressing affliction, the social reproduction of health obviously takes on a more centralized profile.

Other anthropologists picked up the perspective of the social reproduction of health. Peter Berman and other social analysts who have studied health and health delivery using a societal reproduction model, focusing on the household as the unit most likely to

¹⁵⁹ Katz, *Vagabond Capitalism*, 2003.

¹⁶⁰ Janzen, John M. *Ngoma: Discourses of Healing in Central and Southern Africa*. Berkeley, Los Angeles, London: University of California Press, 1992, p. 159. Online: <http://ark.cdlib.org/ark:/13030/ft3779n8vf/>

"produce health".¹⁶¹ Household is defined to include persons who reside together and may or may not be related as kin. Usually those residing together in this close way share the tasks of daily living and caring for each other. It is possible to observe quite closely the manner in which resources are generated by those productive members of the household and shared or redistributed to those who are dependent. Kangas, who uses the social production of health in her account of Yemeni life and health practices, notes that "studies of the "household production of health" critically observe how household members cooperate and compete for resources in order to restore, maintain, and promote health."¹⁶² Such analyses, therefore, highlight the variability in autonomy, status, power, and access to resources existing among household members.

The concept is thoroughly reviewed and discussed in a current dissertation by Kristin Lundberg (2008),¹⁶³ based on her extensive fieldwork among women weavers in Laos. Incorporating Bourdieu's habitus as a framework, but with an eye to areas of methodological practicality, she notes four ways in which health is reproduced: "through relationships, resources, ideology and productive means. The social reproduction of health "requires a marshalling of and commitment to resources that result in a "maintenance of a way of life. Resources enable the individual, within the context of the family and society, to provide the essentials of existence".¹⁶⁴ Lundberg emphasizes the strategies of everyday life in the "identification and attainment of information, social relations, and material goods." Echoing again Bourdieu and the phenomenological perspective, "it is at the level of the lifeworld where practice exists and practical knowledge operates, that health comes to be, or is maintained and is reproduced."¹⁶⁵

In the contemporary setting of globalized post-industrial society, a social reproduction of health perspective needs to look at the infrastructure of health and health care with a keen regard for conditions that create bifurcated privilege—better care and conditions for some, and worsening circumstances for others. Shawna Carroll and Karen Stipp have both proposed to examine the conditions behind and beneath differential access to health insurance in the United States, the only modern industrial society lacking comprehensive public health insurance and care. Carroll studies the determinants and consequences of insured and uninsured working women.¹⁶⁶ Stipp studies the conditions and consequences

¹⁶¹ Berman, P., C. Kendall and K. Bhattacharyya. "The Household Production of Health: Putting People at the Center of Health Improvement." In I. Sirageldin & H. Mosley, et. al. (eds). *Towards More Efficacy in Child Survival Strategies*. Baltimore: Johns Hopkins University Workshop Report. 1989; "The Household Production of Health: Integrating Social Science Perspectives on Micro-level Health Determinants." *Social Science and Medicine*. 38 (1994), pp. 205-215

¹⁶² Kangas, Beth. *Yemen Update*. 35 (1994), pp. 22-27. online: <http://www.aiys.org/webdate/kang.html>

Berman, et. al., 1994, pp. 22-27.

¹⁶³ Lundberg, Kristin. *Women Weaving Well-Being: The Social Reproduction of Health in Laos*. Lawrence, KS: University of Kansas Department of Anthropology, PhD Dissertation. 2008.

¹⁶⁴ Janzen, Ngoma, 1992, p. 153.

¹⁶⁵ Lundberg, *Women Weaving*, 2008, p.

¹⁶⁶ Carroll, Shawna, "Cultural Construction of Disease Risk: A Measure for the Social Reproduction of Health." Paper presented at the meetings of the Society for Applied Anthropology and the Society for Medical Anthropology, Memphis, Tennessee, March 26, 2008, published in the *Vienna Ethnomedicine Newsletter*, Summer, 2008; "The Construction of Cardiovascular Disease Risk among Insured and

of nine million uninsured children.¹⁶⁷ For both scholars the focus is upon commoditized health care, health services, and society's commitment to social reproduction of health. Because health care has become so thoroughly commoditized in the United States, the evidence is strong that there is a social class hierarchy of differential access to that which enables health. Health insurance is not the end all of health, it is an indicator of society's deeper resource flows and structures of jural rights. This perspective is essentially that adopted by critical medical anthropology that concerns itself with the correlaries of health inequality and health disparity.

Carroll examines the variable of health insurance upon women's cultural constructions of cardiovascular disease. Her hypothesis is that women who have insurance will use more of a biomedical model of risk in their understanding of Cardiovascular Disease (CVD), whereas those who lack insurance may use other models of CVD and the functioning of their bodies in relation to risky behaviors. The role of health insurance is hypothesized to play a kind of self-fulfilling prophecy role in the way women relate to their bodies and to the ways they understand the risks of CVD. This study is still in process and we await its outcome.

Stipp notes that children's health insurance accompanies the most important feature of having a "proximal care provider," someone who is regularly consulted by parents when the child becomes ill, or there is a threat to health. And as a consequence, their health is better. The uninsured, by contrast, have no easy recourse to a proximal care provider, thus tend to put off seeking care when children are ill, or they go to the emergency ward, where they encounter different care givers who do not know them or their history. As a consequence they indeed are sick more often, have longer, more unnecessary episodes of ill health, and die more frequently. Stipp develops an ecology of health dimension in her analysis that explores the stresses of disparity in health access upon families. As a result of this pattern and the large number of uninsured children in the U.S., the U.S., ranks rather low in health indicators among industrialized countries. In other words, the social reproduction of health is bifurcated, essentially reflecting an exacerbated class division between rich and poor.¹⁶⁸

These studies and sketches of studies suggest a more precise methodology for the study of the social reproduction of health. Firstly, this inquiry must be based in an understanding of the social arrangements and institutions through which health exists and health care is made available, including the scale of such organization. Secondly, it is important to understand the economic mode—ritual or labor exchange, fee for service, centralized provider-- by which resources have been generated and have been put through these institutional arrangements. Thirdly, it is important to understand the symbolic

Uninsured Working Adult Women in Kansas City." University of Kansas Department of Anthropology, PhD Proposal, May, 2008.

¹⁶⁷ Stipp, Karen "Health Effects of Stress and Social Inequality." Introduction to Medical Anthropology, fall 2007; "Ecological Perspective on Inequality and the Social Reproduction of Ill Health." The University of Kansas School of Social Welfare, February 1, 2008.

¹⁶⁸ Singer, Merrill & Hans Baer. *Introducing Medical Anthropology*. New York: Alta Mira, 2007, pp.151-180.

capital and the knowledge that have been generated within this social and economic framework, and how the symbolic capital and knowledge are legitimized. Finally, the political energy or will that has been asserted to assure that a particular program is actually carried out or sustained. Who are individuals or class of individuals who really make a program happen?

I return to the African context with several case studies of the social reproduction of health that span the range that has been sketched: historical ritual therapies in the face of precolonial mercantile trade; postcolonial governmental action by a concerned mayor who realizes his power to improve his citizens' lives; a Primary Health Care regional system during the collapse of the Zairian state and the outbreak of a deadly epidemic; finally, the impact of HIV/AIDS upon households and communities from a recent history of the epidemic by a well-known Africanist historian.

Case 1: The social reproduction of health in *ngoma*

In my book *Ngoma*, chapter 6 on "How Ngoma Works,"¹⁶⁹ I offered a working definition of the "social reproduction of health" as "the maintenance of a way of life and the commitment of resources to relationships, institutions, and support organizations that directly or indirectly maintain health." Then I examined four widely different historical and contemporary ngoma settings: the historic coastal Congo Lemba order in the context of the 17th – early 20th century mercantile trade at the Atlantic coast; the 20th century Southern Savanna natality-enhancing ngoma orders of Zambia and southern Congo; the late 20th century ngoma orders of the townships, especially Guguleto, of the Western Cape in South Africa; the also late 20th century professionalized ngoma of Dar es Salaam.

To the questions I asked then, I shall add a few and offer this set of review criteria. What type of social fabric was created, reinforced, or reproduced by a particular ngoma order? How were material, human, symbolic and knowledge-derived resources marshalled in those institutional settings? How did this process of organization and problem-solving address health issues and needs? The understanding of "health" and the analysis of "efficacy" in ngoma is best handled within a single tradition or related sets of traditions and orders. However, in many of the ngoma orders, sheer physical perpetuation, that is biological reproduction and survival, are at the core of the ritual around affliction. Much anthropology of these rituals has glossed them as fertility cults without linking them to wider forces. In the backdrop of Western Equatorial and Southern Savanna African concerns with reproduction and survival of households and lineages is a catastrophic demographic trend of declining overall population, and infertility of significant portions of the women of reproductive age.--- Behind these demographic patterns we must also recognize the disastrous global political economy from the 16th century on in which these regions were unable to renew their resource bases effectively. They are, in other words, becoming peripheralized communities or sectors of societies that are attempting to

¹⁶⁹ Janzen, John M. *Ngoma: Discourses of Healing in Central and Southern Africa*. Berkeley, Los Angeles, London: University of California Press, 1992. p. 156 ff.

bring resources together around the worst affliction, namely sheer reproduction.

The typical social units of attention and therapy so identified are individual women, couples and their alliances, or matrilineages. These types of persons or social units are organized as networks and therapeutic cells through the long-term association of master-healer with novice-sufferer, within a larger public of "lay" clients and the assemblies of people at ritual events. Over time such constellations form into regular spider-webs of associations as Harriet Ngubane has identified. This may well offer, in their ability to recreate society, the most pronounced characteristic of ngoma therapy in achieving and maintaining health where it has collapsed, where chronic afflictions have multiplied into several dozen modes—reproductive difficulties, threats to subsistence living, environmental dangers, ominous threats on the margins of reality, the security of those who must journey afar to find employment—ngoma networks and cells have asserted the sharing of adversity, the *communitas* of common suffering, and the hope of continued kindred spirits.

Peripheralization and marginalization does not however characterize all of the ngoma social units and networks. In the historic Western Congo Lemba and in contemporary Dar es Salaam professional healers' other factors are at work. Both institutions are made up of elites that are exercising control over markets, trade and trade routes, merchandise, and even the apparatus of state. Lemba's emblems may be traced back to the Loango state, whereas the Shirika la Madawa ya Kiasili association in coastal Tanzania is required to maintain active ties to the state through registration fees, the presence of a state overseer who monitors the financial status of the Shirika, as well as its political posture toward the dominant party. The structure of master-healer and novice-patient referred to above exists here as well, but it is now a broker of power rather than of marginality.

A retrospective hypothesis for the controlled study of the social reproduction of health would need to provide the following minimal information. What is the nature and extent of social support and its allocation to health-related arenas in the household, the extra-household networks, and society at large? Are there measurable differential effects upon survival of at-risk segments of society or the improvement of perceived health?

Case 2: Reproducing Health in postcolonial communes and territories

This second case in the social reproduction of health is prompted by an interest in Central African postcolonial local governments, in particular the communes that emerged in the former Belgian colonial territories of the Democratic Republic of Congo (Zaire), Rwanda, and Burundi. The position of bourgmestre or mayor has been staffed by persons with varied backgrounds and reputations, including those who demonstrated great skill and forethought in discharging their responsibilities for the safety, wellbeing, economic progress and health of all their citizens. I have been acquainted with a number of individuals who had been teachers and were elected by popular acclaim because of their overall popular appeal.

Kongo ruler/writer **Kusikila kwa Kilombo** was a former teacher and two-term immediate postcolonial mayor from the Kivunda commune in the Manianga region of the Lower Congo. He invited my wife and me to live in his village house during my earliest fieldwork in Kongo society, and appreciated many long and thoughtful discussions over issues I encountered in my research. I knew he had to deal with many problems and tensions within the community he ruled, not the least of which were frustrations over the way that the national government turned into a worse oppressor than the colonial government. His understanding of Kongo society was the most sophisticated I encountered among Kongo politicians and administrators, because he not only could give me the standard explanations of events and issues, he developed original theories that often reflected his wide reading. But most of all he was wise and could theorize his experience. I found his views on power most intriguing because he tied them to *kindoki* - what people called witchcraft - on the one hand, and to sickness and healing on the other. He understood *kindoki* to be the ability of a person to influence and affect others, for good or for ill, an understanding close to the classical meaning of the proto-Bantu term *loka*, the root of *kindoki*, the power of words. Chiefs, elected mayors and presidents, enjoyed legitimate *kindoki*, and needed it to govern; whereas what most people called witches, sorcerers, or *bandoki*, were those who used *loka* in an antisocial, illegitimate, manner. The latter was what people feared. People who had grown up in colonialism did not know what legitimate power was, or looked like. But in Kusikila's understanding it was made up of persons like himself, duly elected, exercising power for the good of society.

The importance of the will of leaders or persons in positions of authority to assert themselves in the enactment of health and wellbeing is evident in this case. Kusikila told me of his experimentations with communities where dissension and chaos reigned, and people were sick. In one such situation he had told the community to clean up their houses and streets by his deadline, or else he would imprison them. Their complaints stopped, as did their sickness. They became his strong supporters. He had used his positive *kindoki* for the well-being of this community.

Kusikila systematized his insights in the booklet *Lufwa evo Kimongi e?*¹⁷⁰ *Lufwa* is the straight-forward Kikongo term for death. *Kimongi*, on the other hand, is translated as pestilence, or foreign or strange death. The two words represent the two opposing poles of the diviner's dichotomy, whether an affliction is "of God," or "of man." However the framework is broader than that of most diviners. Kusikila's describes all the causes of *kimongi*, the strange, unnatural death. Adultery leads to broken homes, sexually transmitted diseases, infertility, and a declining birth rate; Parental ignorance leads to sick children; malice leads to diseases that cannot be treated by medicines. Although there are literal poisons that kill people, metaphorical poisons are more pervasive and injurious—e.g., wrong instructions in school, certain kinds of study abroad that turn the youth away from their home country, the shunning of agriculture, wanting to be like Europeans, and abandonment of one's language. Breaking oaths leads to loss of trust in institutions like courts, economic contracts, and civil servants. The reliance on magic (from Europe) or

¹⁷⁰ Kusikila kwa Kilombo, "Lufwa evo Kimongi e? [Death or Pestilence?], In *Anthology of Kongo Religion: Primary Texts from Lower Zaire*. Eds. John M. Janzen & Wyatt MacGaffey. Lawrence: University of Kansas Monographs in Anthropology, (1974 [1966]), 5.

the lust after easy riches and theft, instead of work, leads to a kind of craziness. Slavery and colonial forced labor led to a loss of well-being and a distaste for work. Finally he comes to witchcraft, where he develops his theory of legitimate and illegitimate power. A country must develop in the vision of its true nature to prosper. Each country has its roots where it must find its future. He closes with a call to enlightenment, to build on science and leadership, to escape the reign of "pestilence."

Case 3: Rescuing Primary Health Care upon the collapse of the state

Ebola struck in Kikwit Hospital May, 1995. Ebola is a viral hemorrhagic fever that affects that kills about 90% of those it infects. There is no known cure. Nor is the ultimate source understood. At first patients, then medical staff, began dying in the hospital. Then those family and friends who washed and buried the dead also began dying. Soon, most of the remaining patients and some of the staff fled the hospital, some no doubt infected. The outbreak of ebola caused international health agencies like the World Health Organization, the International Red Cross, and the U.S. Centers for Disease Control, to spring to action in order to contain and to understand the virus. International medical teams were sent to Kikwit to care for the sick and dying with ultra-caution. Bodies were buried directly, the wards and rooms of the hospital were thoroughly cleaned, and epidemiological surveys were taken.

The importance of Ebola in Kikwit, for our purposes, is the rest of the story that Dr. Pakisa Tshimika told the international press, and this author.¹⁷¹ It is the story of the collapse of the fabric of health, and how Kikwit region responded. Kikwit is the capital of Bandundu, one of the provinces of the Democratic Republic of Congo (formerly Zaire). It is on the edge of the African Southern Savanna, in the midst of vast oil palm plantations, where the Kwango river flows into the Kwilu, on which river barges take the raw oil downstream to refineries. A paved highway links the city to the national capital of Kinshasa in the west, and to the diamond hub Tshikapa in the east.

Kikwit, with a major hospital, was the center of several of the country's 300 health zones created in the 1980s when Zaire developed its own Primary Health Care (PHC) system following the World Health Organization plan launched following the 1976 Alma Ata Declaration of "Health for All." This region of Zaire, like much of the country, was beset with many of basic health problems characteristic of high levels of contagious tropical diseases: an infant mortality rate of 130/1000 births, endemic malaria, resurgence of sleeping sickness, increasing sexually-transmitted diseases including AIDS, tuberculosis, and widespread malnutrition. The Primary Health Care program was one area in which Zaire took positive initiatives during the 1970s and 1980s. In the spirit of the "Health for All" resolution, basic care in the form of a trained nurse with

¹⁷¹ Pakisa Tshimika, Personal Communication, published in John M. Janzen, *The Social Fabric of Health: An Introduction to Medical Anthropology*. New York: McGraw-Hill, 2002, pp. 255-257

essential drugs was to be accessible to all. No one was to have to walk farther than 15 km for this care.

Each health zone was organized into local primary health centers, regional mid-level centers, and a central regional hospital. In the local centers nurses carried out basic care and public health initiatives such as inoculations. Ideally they were to see and refer the most serious cases up to hospital centers. Medicines and other resources were distributed from central stocks to the local centers. Kikwit Hospital served as the center of such a set of zones, the supplies were brought in from the national PHC supplier, international health agencies and churches. Because of the unreliable nature of state medical supplies, the Primary Health Care system in Zaire was purposefully created in such a way that parallel sources of medications and other governments (notably United States Assistance for International Development (USAID)).

This "redundant" supply system was proposed in the late 1970s and early 1980s. In one region of Bandundu, here is how this happened. In 1984 Dr. Tshimika, who is from the southern Bandundu "Chokwe" region, invited physicians from regional private, state, and church hospitals together at his hospital, a church hospital, and with a representative of the Ministry of Health, the group organized as six participating hospitals, each of which would coordinate local health centers from which they would also receive referral cases. Dr. Tshimika and many other medical personnel worked hard to find local and foreign "sponsors" for their health zones.

Then, in the late 1980s, the Zairian government's role in the Primary Health Care system deteriorated. Inflation soared to 1000%/year, in one period of two months there were five Ministers of Health. The entire national budget became unreliable. At this point the government effectively and by default got out of the health care business entirely. The Ministry of Health became non-functional, like other ministries of the Zairian government. Observers began to speak of the "collapse of the state." The 1991 riots in Kinshasa by Zairian soldiers and the destruction of many private enterprises brought the country into a state of deep moral crisis. Along with the collapse of infrastructure institutions like the mail, roads, and ferries, now too the primary health care zones fell apart because governmental workers were no longer paid, or if paid, their salaries were as worthless as the hyper-inflationary currency. After the riots in 1991 the foreign partners like United States AID, Canadian CID, Belgian assistance, and organizations like OXFAM and UNESCO withdrew because it became impossible to conduct their affairs in the midst of such chaos. Medicine stocks were stolen, vehicles were taken for private use or stolen, personnel abandoned their posts. The national primary health care office was finally closed in 1994.

The health care consequences of this, states Tshimika, were increasing mortality and morbidity, disease such as measles and TB thought to be under control began to increase. Sleeping sickness epidemics broke out anew in along rivers. Typhoid and paratyphoid, previously unknown, appeared. And then came the

outbreak of ebola in 1995. Dr. Tshimika was contacted by the international media because of the worldwide fear of this outbreak. But it was just the "tip of the iceberg," he said, revealing the extent of the disintegration of the health service infrastructure in Zaire as a whole.

Dr. Tshimika, who had once helped organize a neighboring zone in the area of Kajiji to the south of Kikwit, and had played a central role in Bandundu public health planning, was also one of the individual who could see the consequences of its collapse around 1990. He now became involved in trying to salvage public health in Kikwit through the creation of a local network of non-governmental organizations (NGOs). Local supervision by motivated and interested individuals became everything in new efforts at public health. In this sector, as in education and food production and distribution, private initiatives were all that was left. Where village nurses understood the issues, local clinics survived. The same was true of hospitals and clinics. But many of these now of necessity became fee-for-service operations, looking for support from outside agencies of the church, the United Nations, or other private sources. In Zaire and elsewhere in Africa, the Non-Governmental Organization (NGO) became the structural where-with-all of health care delivery. Western governments had totally withdrawn from the Zairian scene. "The Zairian crisis" had become a way of life, Dr. Tshimika observed.

Out of the remnants of the old Primary Health Care structure, a consortium of local institutions created a platform for the maintenance of public health. The loosely affiliated consortium called The Council for Development of Bandundu Health survived. It was able to play a major role with the Ebola epidemic. Its participants included: the organization Dr. Tshimika headed, the DESADEC/CEFMZ, a Mennonite Health and Development Agency; OXFAM Bandundu; Kikwit Catholic Diocese development department; Program Elargi de Vaccination (PEV), a government branch mainly subsidized by UNICEF; Resseau Femmes et Developpement Bandundu, a consortium of women's NGO's of Bandundu; Medecines Inspecteurs Urbaines, a group of Zairian physicians who had been involved in medical inspections; the Kikwit Catholic Diocesan Pharmaceutical Depot; and the Medecin Chef de Zone Kenge, one of the remaining health zone administrators. What is noteworthy of this group is that, although containing remnants of government, it is made up mostly of church and local civic groups with a keen desire to avert epidemics and to somehow maintain basic health services. A measure of the devotion of these groups to their cause is that all serve as volunteers. Some of the agencies are affiliated with outside international institutions which give some support. The corporate structure of the Council is however totally decentralized, existing by the good will and common interests of its participants. As a set, these agencies working together were able to maintain some of the essential services that required the coordination of trained doctors and nurses, a dependable source of medicines, the support of the women, and the devotion of the churches.

In 1995 most politicians and higher-level administrators had become enemies of the people in Zaire, allied with the corrupt dictator Mobutu. In Kikwit they were agitating to expel one of the ethnic groups whose members included some successful merchants with trucks. This was widely regarded as a diversionary tactic to maintain control. By mid-1997, the government of dictator Mobutu was ousted by a rebel army that originated in the east of the country.

Although Dr. Pakisa Tshimika is not a medical anthropologist, he has led and participated in the campaign to create primary and public health structures in his region of Central Africa during good times and very bad times.

Case 4: HIV/AIDS-- Treating, Preventing, Grieving, and Assessing the Impact

Much has been written on the HIV/AIDS epidemic in Africa. But John Iliffe's *The African AIDS Epidemic: A History*¹⁷² is perhaps the first major writing project to offer an authoritative and detailed account of the epidemic from its inception to the present status of combating it, for which he uses the term "containment". Much is noteworthy in this volume, including an emphasis on regional distinctiveness in the unfolding of the epidemic, a carefully laid-out narrative of official responses and strategies, popular perceptions and actions, as well as the approach taken by international organizations. In this case study I will focus on Iliffe's chapter 11 entitled "Death and the Household" because it offers a review of new research on the impact of the epidemic on the social reproduction of health.

By focusing on the household, Iliffe is able to cast into sharp relief the contrasting impacts of AIDS infection, prolonged care, and death of particular family members, and whether or to what degree the household survived. Affected households can be compared to those that are less affected, and strategies of collaboration, sharing decision-making and resources, are easily traced at this scale of research. AIDS in the African context—especially Central and Southern Africa where infections rates were highest—had unique features. As a mainly heterosexually transmitted infection, it hit the young adults hardest, those who were sexually most active. Also, it "was a disease of impoverishment" since these were the work force of families. There were other dimensions that made it unique in this setting. The ethic of care within the family meant a burden of time, usually 18 months from onset to death, followed by the equally strong ethic of providing a proper burial, which usually cost as much as the care, although the cost of burial and of a respectable funeral was more widely shared by burial mutuals and in inter-family and kin exchanges. By 1999 AIDS had become sub-Saharan Africa's leading cause of death, and within another half decade 13 million had died, over 2 million were dying each year.¹⁷³

Iliffe's research includes official reports, but the most exciting sources are newly-researched dissertations and research findings by individual scholars, some of whom, like

¹⁷² Iliffe, John. *The African AIDS Epidemic: A History*. Oxford: James Currey. 2006

¹⁷³ Iliffe, *AIDS: A History*, p. 113

Gabriel Rugalema, are analyzing their own home communities and regions.¹⁷⁴ From the Kagera region in northwest Tanzania, Kagera town and surrounding villages were hard hit, such that by 1996 32% of households had experienced deaths, and 29% incurred major obligations through the terms of existing relationships. Rugalema established that treatment costs and time commitments for one 18 month AIDS victim was the equivalent of a year's household income. The spouse or other household caregiver would spend 45-60 % less time than normal on agriculture, or would allocate these tasks to children, especially girls who often had to stop attending school.¹⁷⁵ In wider reference to other studies from Chad, Ethiopia, and South Africa, Iliffe reports that a broad pattern is for households to expend about a third of their income on healthcare if AIDS is present.

A bifurcating pattern emerges in Iliffe's portrayal of households coping with AIDS. Some benefit from trans-household social contracts and exchanges, whereas others—the poor and not well connected-- spiral downward into dissolution. Rugalema highlights the therapy management group process in the search for treatment options and in responsibility that is shared more widely than just the household. Central Africa's kinship structures, emphases on alliances and voluntary associations, appear to provide much of the death costs of respectable funerals and burials. Surprising to Iliffe is the extent to which most regions hit by the AIDS epidemic avoided the total collapse into chaos and poverty that was predicted by many. Yet the households that imploded, as the main caregiver became sick and died, and sometimes both adults died, presented grim alternatives for the survivors. The most impoverished households were those headed by widows. Sometimes households of surviving orphans managed to continue, especially if a teen-aged daughter who had learned to cook was present. But usually such households were dissolved, the children joining the growing ranks of AIDS orphans, which by 2004 were estimated to number 12 million in Sub-Saharan Africa.¹⁷⁶ But again the African kinship structure came to the rescue as many of these orphans were taken in by relatives, parents' siblings and grandparents. Still, all towns and cities in the AIDS belt of Sub-Saharan Africa witnessed large numbers of street children, most of whom had lost both parents. NGOs sometimes came to the rescue, and in other places like South Africa the government created programs to support them. Unassisted orphans however created the haunting specter of social collapse that gave rise to witchcraft accusations and vigilante killings of these children.

An added dimension of the social reproduction of health resulting from the AIDS epidemic was the negative impact on food production. This meant the exacerbation of already downward trends. From 1960s to the 1980s food production fell by about 1% per year. Iliffe summarizes the research to show that a bifurcating trend emerged as a result of AIDS poverty in agriculture. Widow-headed households, grandparents-headed households with grandchildren, generally struggled and cultivated smaller areas. Larger, wealthier households might even add to their available land holds by taking over the land

¹⁷⁴ Rugalema, Gabriel H.R. *Adult mortality as entitlement failure: AIDS and the crisis of rural livelihoods in a Tanzanian village*. PhD thesis, Institute of Social Studies, The Hague. 1999; "Coping or struggling: A journey into the impact of HIV/AIDS in southern Africa." *Review of African Political Economy*. 86 (2000), p. 12.

¹⁷⁵ Rugalema, 2000, cited in Iliffe, AIDS, p. 115.

¹⁷⁶ Rugalema 2000, cited in Iliffe AIDS, p 118

and livestock from the poor. In professional circles, upper management in businesses and healthcare professionals were seriously hit by the AIDS epidemic, especially in Southern Africa.

This overview of the impact of AIDS in Central and Southern Africa on the social reproduction of health needs to take note of the state's role in setting policy and charting a course of action to combat the epidemic. The moving front of the epidemic was very dynamic, and varied from region to region. Until 2000 the main methods of intervention were prevention through health education, the promotion of condoms, and testing in high risk groups. In the 1990s Uganda's ABC program, created by national policy leaders in all relevant institutions mapped out a bold effort to lessen sexual encounters (A= Abstain, "no grazing"), lessen partners (B = Be faithful) and resort to condoms if engaging in sex with partners now well known. The program brought Uganda's infection rates down from 35%, the highest in the world in 1990, to 6% a decade later. Policy makers and AIDS planners were asking, Can the Uganda program be replicated elsewhere?¹⁷⁷ The rising availability of anti-retro-viral drugs around 2000 changed the picture dramatically, for the first time offering if not a cure, at least the prospect of a longer life with AIDS. Once anti-retro-viral drugs became available, Botswana, that at 2000 had the highest infection rate in the world of 35%, became the first country to be able to afford and commit itself to providing drugs to every infected countryman.

Uganda's "ABC" program has now become legendary for its remarkable success in bringing HIV/AIDS infection rates down from over 20% of the population in 1991 (the highest in the world at that time) to 6% in 2000.¹⁷⁸ Analysts who have studied the early years of this program in the late 1980s, and have compared it with other programs, have begun to identify the major reasons for its success. The leadership, outspokenness, and insistence on transparency by President Yoweru Museveni is recognized by all as important. The removal of stigma from AIDS sufferers was important in permitting those who were infected to be honest about their condition, and those who related to them to work out methods of not transmitting the infection. The engagement of religious leaders was also important in bringing issues related to HIV/AIDS into the forefront of national consciousness. The broad multi-sectorial involvement of over 700 organizations, ministries, and NGOs demonstrated that this was a single-minded national priority. Thirdly, observers identify the participation of the schools extremely important in the transformation of sexual attitudes and behaviors among students and young adults. From 1987 on general sex and focused HIV education were carried out in primary schools, leading to a rapid decline of infection rates in the 14-25 year age group. A fourth reason noted for the success of Uganda's HIV/AIDS reduction program was that promoted the empowerment of women and youth, everywhere the principal victims of rampant AIDS epidemics.¹⁷⁹ Other features of the Uganda approach included the training of healers in AIDS prevention education and palliative treatment, and generally the open discussion of the issues facing the nation.

¹⁷⁷ Green, Edward C. *Rethinking AIDS Prevention*. New York: Praeger. Green 2003, pp. 141-226)

¹⁷⁸ Green, *Rethinking AIDS*, p.143.

¹⁷⁹ Green, *Rethinking AIDS*, pp. 169ff

The African HIV/AIDS scene continues to evolve, as health agencies, donor governments, national ministries, and researchers juggle the provisioning of new medications to keep the infected alive and reasonably health, as well as continue the educational work of bring down infection rates. Experts debate the most effective methods of intervention. Research demonstrates that the reduction of sexual partners is the single most effective measure to achieve this, while proponents of sexual rights within the Western public health community, as well manufacturers, promote condom use.

Conclusion

The line of inquiry that I have pursued here may be distilled to four questions asked of each of the case studies. First, in what kind of social organizational or institutional framework is the health measure couched? Secondly, how are resources generated, marshaled, or created out of scattered elements of human life to direct to health? Thirdly, what legitimacy is granted the initiative, what ideology, theology, or symbolic framework? Fourthly, how is political will or praxis manifested in resolving the health crisis or dilemma? "Structure," "means," "legitimacy," and the "will to praxis" might be the code words with which to remember these points.