Science and Spirit in Postcolonial North Kongo Health and Healing

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Abstract: The Kongo region—the Lower Congo—from the 1960s until the present (2014) has seen the significant decline of mortality and natality rates, the tripling of the population, significant emigration, and the advent of family planning. In medicine, "biomedicine" (the medicine of global medical-school-taught doctors, nurses, lab technicians, and pharmacists, and related medicines and techniques) has become pervasive, largely replacing the tradition of the *nganga* and the *min'kisi.* However, the complex, socially-driven questions about misfortune continue to be asked by individuals and families; the examination—*mfiedulu, kufiela, kufimpa*—of relationships continues to be practiced by a variety of specialists (*nganga, ngunza,* family gatherings); a more expansive personhood common in Central, and Sub-Saharan Africa requires rituals of protection and holistic healing by *ngunza,* pastors, priests, biomedical doctors, and psychotherapists who minister to the "whole person" and the social group. Thus, while science has become the defining reality of medicine, the role of spirit—ancestral, social, religious—has persisted and in some respects even strengthened because of the loosening of social bonds and the chaos of the political order. The paper will explore examples of these trends identified in the author's recent field research in Lower Congo, while making the case for an enduring Kongo or Western Equatorial African culture of health and healing.

Introduction

This paper sketches the state of health in North Kongo society, with a focus on changes in the postcolonial period since 1960; of initiatives taken, and institutions developed, to address the disease challenges and to improve the quality of life of the people of the region. This overview is informed by fieldwork in the 1960s, and more recently in 2013.[1]

"Science" and "spirit" are shorthand terms that represent two prominent aspects of health and healing in postcolonial Kongo. This distinction is not a dichotomy between present practices versus past practices, nor between foreign-introduced biomedicine and traditional medicine. Rather, it has to do with the advance of understanding and practice of science in the

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service of healing, as well as continued use of spiritual healing and views of the world that engage spiritual forces—human as well as non-human.

A sophisticated and nuanced anthropology is required to bridge the science and spirit continuum. Health as embodied in birth and death rates, and epidemiological trends of diseases, are readily amenable to quantitative indicators as seen in publications of the World Health Organization, local Health Zones, and government reports. Yet health is also interiorized in bodily and organic functions; it is exteriorized in words, signs, symbols, and sentiments that are projected onto relationships that affect health or sickness, suffering or joy. Health is thus studied through philosophical abstractions of themes that guide or reflect domains of social action.

The project I conducted in 2013 utilized several anthropological methods, beginning with that hallmark of anthropological fieldwork, participant observation—just hanging around, watching others, and being part of the action if possible. Activities seen or formulated in a particular context may serve to render visible ideas, values, or cultural conceptions and connections between them. I observed particular cases of illness, in their trajectories in the pursuit of healthcare, as well as the activities and organization of medical institutions.

The questionnaire I developed and administered to one hundred and five households in Luozi and in the North Kongo (Manianga) region provided a more balanced understanding of specific areas of behavior, knowledge, values, and opinions.[2] It identified household composition; occupations; illness episodes experienced in past year, treatment, and outcome; hygienic conditions around the house; the meaning of health (*mavimpi)*; and family planning. This sample of was "opportunistic," in the sense that it included groups intentionally selected for their likely differences in health and disease manifestations. In Luozi this included middle class—professional—and other households that benefited from the city's potable water system, as well as those in outlying communities that did not have clean water; also, households of merchants, government administrators, teachers, and members of churches that practice healing. Included intentionally were households of cultivators who live beyond the city water system, of fishermen on the river. During a trip to the Kivunda region, we interviewed a similar cross-section of cultivators, educators, and craftspeople. From all these groups, we sought to include equal numbers of women of different age cohorts.

Important information for this study was sought in public records of the city, territory, in church offices, and publications available in libraries and individual holdings. Particular attention was paid to the Health Zone office where since 1984 public health initiatives have been made and records kept, and in the documents of church organizations charged with administering medical institutions.[3]

This research project would likely not have been possible without the key role of Professor Kimpianga Mahaniah, founder and CEO of the *Centre de Vulgarisation Agricole* of Luozi and Kinshasa, and Rector of the Free University of Luozi. When I wrote him in 2011 about my interest in returning to the Manianga for a research project on health he offered endorsement and scholarly expertise, as well as a generous supports in Luozi—lodging, caretaking staff, vehicle, and a circle of "handlers" who not only looked after us, but introduced us to a range of contacts in government, healthcare, education, and the community.[4] They were generally aware

of the nature of anthropological research and were interested in the outcome of this research. I could not have hoped for a better support network.[5]

Population Trends, Diseases

The tripling of the population of the Manianga region, the wider Lower Congo, and the societies of Equatorial Africa in general, since the 1960s, despite the periodic wars that have ravaged the region, is attributable, in a strict statistical sense, to the decline in mortality rates. This includes a declining infant mortality rate from ca. 200/1000 births to around 50/1000. Much of the increase in population has been absorbed by temporary or permanent emigration to the urban centers of the region—Kinshasa, Luanda, Brazzaville, Pointe Noire, Mbanza Ngungu, Matadi, Boma, etc.—and overseas to Europe and North America. The population side of health is also shaped, especially in recent decades, by a significant rise in family planning, especially among young educated adults, who regularly limit the ideal (and actual) number of children to two or three, in the place of their grandmothers' six to eight.[6] The beginning of the modern rise in population in the Lower Congo dates to the 1930s, following a catastrophic estimated 50 percent population loss during the Congo Free State period (1885-1908).[7] This was due to spiking death rates from forced labor, flight of communities to protective lowland forest areas, and subsequent epidemic diseases.[8]

This picture of postcolonial health, cast against the global improvement in knowledge of, and medicines for, the major diseases of the tropics, is the half-full glass of this story. Sleeping sickness, the early twentieth century scourge of this region, is now well understood and is limited to occasional outbreaks, rarely leading to deaths, handled with special medicines and tsetse fly eradication methods. Malaria remains the most prevalent health challenge, but it is well understood and interventions are available, expert clinicians treat crisis cases, and medications are usually available. Pit latrines are the general rule in towns and villages of the area. Clean water sources—encased springs, wells, and urban water systems—are the rule, or at least understood to be essential in safeguarding public health. Continuing chronic diseases such as infant diarrhea, typhoid fever, respiratory infections, seasonal flu, protein malnutrition in some infants, and HIV/AIDS continue to take their toll on health of many. Tuberculosis has reappeared. Inhabitants who make their livings in rivers and streams, i.e., fishermen, are commonly infected with schistosomiasis.[9] The half-empty glass side of the story is that the major diseases are still infecting people, causing their worst damage on the marginalized poor, especially children, and those at a distance from medical help.

Public Health and the Health Zones

The public health program, an outgrowth of the World Health Organization's 1980s Primary Health campaign, is a critical structural improvement in the overall health of the Lower Congo (and Kongo), as well as across the DRC. Under WHO auspices and the Ministry of Health, approximately three hundred Health Zones were created in the mid-1980s out of the somewhat haphazard set of mission, state, and private institutions. A Health Zone population of around fifty thousand inhabitants was to be served by many health posts (staffed by at least one nurse), which reported to and referred patients they could not treat to Medical Centers (that had at least one physician, nurses, a pharmacist, and aides). Each Health Zone is defined around a

central referral hospital which is staffed even more fully than the medical centers. The Health Zone system has become the dominant administrative structure for health and healthcare administration in Lower Congo, and in many regions across the DRC, as well as Angola and Congo. Since the collapse of the national ministry of health and the Zairian state in the 1990s, these Health Zones are administered by recreated Catholic and Protestant church medical organizations, resembling the late colonial and early postcolonial mission medical entities, but now run exclusively by Congolese physicians and administrators. Apart from some high profile inoculation campaigns—children's vaccinations and vitamin supplements, polio eradication—all financial outlays are based on fee-for-service paid by the patients; or grants and NGO involvements that are secured by the necessarily-entrepreneurial heads of the medical services. This situation is ample demonstration of a neoliberal economy in which there are virtually no public funds available for healthcare.

Portraits of Postcolonial Healers

In medicine, "biomedicine" (the medicine of global medical-school-taught all Congolese doctors, nurses, lab technicians, and pharmacists, and related medicines and techniques) has become pervasive. In the Manianga region, one physician serves about six thousand inhabitants (there were twelve physicians for seventy thousand inhabitants), and is assisted by nurses and nurse-practitioners, medical assistants, lab technicians, and pharmacists. All of these practitioners are Congolese. The medical doctors were trained in several medical schools—mostly in Kinshasa—and overseas. Other medical workers were trained in a variety of regional educational institutions. The Free University of Luozi, for example, trained nurses and medical lab technicians.

For this brief presentation on contemporary healing in the Kongo region I will profile individuals whom I have met who typify the important work that has been done on health and healing, and the type of specialties they represent in the broader picture of "Kongo healing." Given my field research in Lower Congo over the span of nearly half a century, I will offer several flashbacks to somewhat earlier—but still postcolonial—moments, and individuals, to establish an historical perspective revealing certain trends but also persisting patterns.

Among the fully qualified Kongo physicians, I begin with Dr. Joseph Kapita Bila, a prominent Kinshasa-based medical doctor. Earlier a cardiologist at Mama Yemo Hospital, he is noted for likely being the first professional physician to have recognized and begun to track the African AIDS epidemic in the 1980s.[10] After leaving Mama Yemo, Dr. Bila took up practice in a clinic in Kinshasa-Gombe—the CMC Clinique BILAM—where he specializes in internal medicine, cardiology, and vascular conditions. He sees many prominent Congolese. Like many Bakongo, Dr. Bila has close ties to his home region and community. Thus, in addition to his urban clinic, he maintains a well-staffed and stocked clinic in his home village of Kisemi west of Luozi, which he visits several times per year.

Many other individual Congolese and Kongo physicians offer skillful and steadfast service in one of the network of official hospitals and medical centers in the face of severe budgetary and infrastructural challenges. One such individual is Dr. Rose Ndoda Kumbu**,** head of the Catholic hospital (medical center) in Luozi. I also mention the Protestant hospital at Sundi-Lutete, in the Manianga north, where a valiant effort is being made to continue the services of a

maternity and regional hospital, including surgery and general internal medicine. All three of these institutions—Kisemi, Luozi Catholic, Sundi-Lutete Protestant—were incorporated into the Health Zone structure as *Centre Medicales*, hierarchically mid-way between the *Hopitaux de Reference* (one per Zone) and the many *Postes de Santes*.

What Happened to the Medicine of the *Banganga*?

The healing traditions of the *banganga*, *bilongo*, and *min'kisi* are like shadows or memories in popular consciousness that may spring to life under special circumstances. Many of the *banganga* I had known and studied in the 1960s, such as Nzoamambu Oscar of Mbanza Mwembe, had passed away leaving no apprentices; or they had early in the twentieth century converted to Christianity and abandoned their practice.[11] This was the case with *nganga* Lemba Katula Davidi**,** who went to Nkamba in 1921 to see Simon Kimbangu the visionary *ngunza*-prophet with his own eyes.[12] He gave up his Lemba initiation, went to school, and became a teacher.[13]

Of the few of which I am aware who had an intensive apprenticeship as *nganga* and went on to practice one or more of the areas in which they were trained, and in turn trained their own apprentices, I note the example of a prominent North Kongo bone-setter, *nganga lunga* Makunza Zablon**.**[14] He had been initiated in the early twentieth century to *minkisi* Ngombo (divination with a basket), N'kondi (conflict resolution and social sanction, using canine or anthropomorphic statues), Mpodi (the cupping horn to extract pollution from a body), and the very arduous *kinganga lunga*, bone setting and the healing of sprains. Because the colonial government and missionaries perceived the orthopedic work of the *nganga lunga* to be relatively free of ritual, they allowed him to practice unhindered. However, he ceased practicing the other *min'kisi* because of interference from missionaries and government officials. The ritual framework of his *kinganga lu*nga was limited to a generic prayer before his massages and bone setting operations, and the medicinal and technical manipulations required to set fractures. Also abandoned was the initiation requirement to "fall" out of a palm tree and hit the ground without breaking bones or injuring muscles, so as to demonstrate an existential knowledge of this most common and serious injury to likely prospective clients. His apprentice Davidi carried on after his death, and I understand initiated his own apprentice who continues the center today.

Popular Knowledge, *Materia Medica*, and the Rise of the Pharmacists

Many Congolese, especially those who go to their gardens and fields to cultivate food crops, avail themselves of a wide variety of plant materials to protect their health. A poltice of a particular tree's leaves, rubbed over skin, is known to repel mosquitoes, thereby lessening the chance of malaria infection. Another plant's roots and leaves provide an effective tea for cough and upper respiratory infections. A few medicinal plants and other *materia medica* are available in local markets, but not nearly as voluminous as in the 1960s. Programs to valorize "traditional medicine" collapsed alongside other initiatives of the Zairian state in the 1980s and 1990s.

Pharmacies expanded like mushrooms in Western Equatorial Africa's cities and towns, however, as did the numbers of pharmacists and pharmaceutical merchants. The neoliberal economic climate and the absence of strict controls on imported drugs meant that any merchant

could buy and sell pharmaceutical products and turn a profit. Still, the popularity of, and belief in, the efficacy of medicinal plants and the high trust in a *nganga*'s use of plants, meant that anyone who tried to work with plants could also gain a clientele. A few pharmacists with advanced training succeeded in subjecting local *materia medica* to scientific examination and the production of new plant-derived medicines. Montreal-trained pharmacist Flaubert Batangu Mpesa founded the *Centre de Recherche Pharmaceutique de Luozi* to develop patented medicines that eventually concentrated in the production of Manalaria and Manadiar, a prophylaxis and a cure for malaria.[15] Batangu's initiatives, begun with dozens of medicinal plants, have achieved significant production and widespread marketing to over a million customers annually. His industry employs forty gardeners, lab technicians, chemists, administrators, and other workers. Batangu, former parliamentarian and currently rector of the *Université Kongo Mbanza Ngungu*, aligns his program with the WHO's malaria control and eradication guidelines that strive to develop medications that avoid drug resistance in mosquitoes and spirochetes, a serious problem with several generations of synthetic anti-malarials. By contrast, Batangu's work emphasizes the value of biochemically complex natural medications, even cocktail preparations, in the manufacture of his major anti-malaria drugs.[16] In the process this group and others like it have engendered a strong consciousness of the significance of evolutionary theory in their understanding of how drug resistance works, and what to do to combat it effectively.

Divination: Why so Prominent?

The non-material dimension of the *nganga*'s tradition has also retained its popularity, and seen significant creative evolution. Questions about misfortune continue to be asked by individuals and families. The examination of social and spiritual background —*mfiedulu*, from *fiela*, to examine, or *fimpa,* to research— is practiced by the occasional *nganga ngombo* diviner (or people who are called that), but mostly by family gatherings, *bangunza* inspirational prophet-seers, mainstream religious counselors, and academically-trained psycho- and socio-therapists. Marie Kukunda of the North Manianga was a particularly striking example of this type of divination in the 1960s.[17] As a deaconess in the Protestant Church, but also a recognized *ngunza* (due to her visions, remarkable recovery from a near fatal disease), she used her Bible as an "instrument." Sometimes she simply sat back, closed her eyes, and pronounced her diagnosis and a recommendation for further steps to be taken in the case at hand. Although she has passed on without leaving an apprentice successor, others continue her style of investigative divination.

Investigative divination is controversial because it readily risks evoking counter-charges of false witchcraft accusation and may lead to serious outbreaks of violence. For this reason *bangunza* told me that they avoid revealing their analysis of relationships and causes to clients because it is too dangerous. Events of 2008 in Luozi still made my interlocuters skittish on the topic of investigative divination. In 2008, a series of investigative divinations by an *nganga ngombo* over sudden deaths led to the identification of several witch suspects, and their subsequent burning by mobs that morphed into anti-government riots in two local *secteur* posts. Regional authorities called in the national army special forces, and a confrontation with the riot-forces ensued, in which up to thirty of the rioters were killed. This unrest was associated with the nativist-nationalist movement *Bundu dia Kongo* (BDK) headed by national parliamentarian

Moanda Nsemi.[18] After the "return to order" the BDK was banned as a political party, but the sentiment the BDK represents is still felt locally and across the Kongo region. My 2013 research did not provide the time to conduct a thorough investigation of divination practices, although I did learn of numerous instances where research into the causes of misfortune were conducted, mainly by *ngunza*.

A continuum of types of cases are brought to investigative divination in my Lower Congo postcolonial review and ethnographic research, ranging from simple aches and pains, to child-rearing dilemmas, to fights over property, to major inter-clan histories of dispute and ill will, to instances of power-mongering, that is recourse to mystical or magical revenge and protection. Prophet-diviners receive a host of aches and pains that they determine to be straight-forward, transparent, with "nothing else going on." Marie Kukunda's cases included "woman with pain in back" diagnosed as "a boil that will soon surface." Marie prayed with her, blessed her, and sent her on her way. Her dictum of this case was "what is hidden will come to light; truth will prevail." Another woman had "pain all over," to which she sat with eyes closed before pronouncing "God will help you," and blessed her with hands on chest and back. Other cases were identified as caused by troubling thoughts or anxiety, rather than anything specific. An elderly man was told his troubles were not witchcraft, but caused by too much drink; he should give up palm wine and change his ways. Sometimes infants with colds and fever were treated the same way, with a blessing and an injunction to go seek care and medication at the dispensary.

A further type of case is identified by investigative *ngunza*-diviners as caused by domestic or work-related conflict, or faulty parenting. This type of conflict is assumed by both the clientele and the diagnostician to cause affliction amongst those involved. Thus, a mother's "pain all over" is linked to money a child has stolen. Marie urges the parents to confess a bad attitude toward their child, that their own parental manner has caused the situation. She administers a painkiller of the *kinsangula* plant to the mother, and tells her to visit a dispensary. Generally parents' discord can cause children's affliction or errant behavior, in her view. Some cases of sickness or misfortune are like links in a whole chain of problematic behaviors resulting in toxic relations. A young man has gotten in trouble in school through bad notes seen by authorities, is expelled, ends up in prison. Marie declares to the youth and his father that he has not been cursed—this is another case of an eighteen-year-old girl who is at odds with her mother over whether she may live independently in the house of her late grandmother, for whom she cared. Mother fears she is having affairs with boys. Marie urges the girl to ask forgiveness of her mother, and for the mother to accept the girl's freedom, as she is nearly engaged. Another case involving sickness and an unfinished bride price is comparable to this one, in that the parents' dispute of the appropriateness of their daughter's relationship to a husband is interpreted to be at the root of her lingering illness. Another reading of this case could be that the failure of the suitor to complete the bride payment evokes the parents' irritation, and causes everyone anxiety, misery, and sickness. Another woman asks for Marie's blessing. In her divination she "sees" a basket, which the woman confesses has figured in an argument with a neighbor. Marie chastises her for engaging in such ungodlike behavior.

A more complex kind of case that appears before investigative *ngunza*-diviners combines disease or misfortune with conflict and recourse to mystical or ritual power. These kinds of

cases go well beyond a conflict that can be managed back to resolution and restoration. Diagnosis and response requires dealing with the affliction, the conflict, and the mystical loop that connects them. A young student with epileptic attacks is brought to Marie by his maternal uncle guardian. Marie's diagnosis is that his affliction is due to his having acquired a fetish for intelligence and force in fighting. This power has overwhelmed him, causing his distress. Her solution is for him to ask forgiveness of his uncle. Hidden thoughts and motives must be divulged; transparency can restore well-being. This is also the diagnosis of a case that involved lightning striking near a young man on a journey in search of work and having sold a used sewing machine gotten illicitly from a white man. The youth's aunts' prayers to ancestors are a hindrance to resolution of the case, says Marie. Proper parenting must be restored, and the sewing machine returned to its original owner. She blesses the youth, reads a Psalm, and encourages this family branch to reconcile with the other one from which the sewing machine was taken. A crisis over a shared "stolen" machine, a bolt of lightning, and invocation of ancestors raises the pitch of this case to a feverish, mystical level that Marie tries to calm with recommendations of reconciliation and restitution.

The most complex cases Marie and more recent diviner-prophets face are outright political conflicts that pit one clan against another over land, reproductive success, and control over one another's status.[19] In one case a former slave clan remnant had fled their masters, leaving with a curse upon their land and women. The master clan began to dwindle, and were greatly concerned that this was caused by the curse. A prominent member of the former slave clan was sick with terminal cancer. Marie arranged meetings between the two clans, and a grand several day long gathering was held at which the curse was withdrawn, a counter blessing extended, and a grand feast celebrated the "descent of the *kodia* shell." In her divination of the cancer case Marie suggested that the sufferer had in his youth struck a twin, setting off a spiritual crisis that had festered and caused his disease. This diagnosis, directed at a spiritual or cosmic force—twins, dyadic embodied spirits—was far safer, from a political perspective, than accusations of witchcraft among the living. Multiple levels of linkage between individuals, clans, and spiritual beings and forces required an equally complex, multi-faceted series of rituals.

Healing, Defending, and Protecting Individuals and Society

The range of cases that Kukunda handled on her own are dealt with in many of the prophet churches with their rituals of healing, purification, and protection that seek to re-situate the individual or household in a more favorable relationship to spiritual power and social context. For example, the *Communauté du Saint Esprit en Afrique* (CSEA) "healing" begins with a question to the seated individual as to the source of distress. I am told that this is often counseling has already occurred prior to the beginning of worship. After the *ngunza* prays before the client, he begins to tremble to the accompaniment of heavily rhythmic singing-dancing by the congregation. The *ngunza* then lays hands on and finally performs a circular dance around the "patient." This motion is at first in a clockwise direction (to unwind the bad or troubled aura around the individual). Eventually, with the help of a white towel waving, he repeats the circular dancing, this time in a counter-clockwise rotation, all the while flapping the towel to create spirit, "*mpeve*." Thus the individual's protective aura is re-established or strengthened. The "weighing of the spirit" tests the strength of this spirit or aura around the individual.

Although this idea of the aura is deep Kongo, it is today interpreted as a manifestation of the indwelling of the Holy Spirit.

The work of protection and stabilization of individuals and groups also appears in modern psychotherapeutic initiatives. These too represent Kongo healing. Dr. Denis Bazinga, formerly of the Neuropsychiatric Institute of Kinshasa, is the founder of the *psychopalabre*, a form of group therapy or psychodrama in which participant patients role play familiar personal, family, and social dilemmas, and then discuss them with reference to psycho-social health. Begun in the 1960s, Bazinga continues his own clinical work under auspices of the Kimbanguist church, which hosts extensive educational, medical, and social services.[20] His successor Valentin Ngoma Malanda continues the therapy at the Neuropsychiatric Institute affiliated with the University of Kinshasa.[21] The psychodrama is usually an extension or a facilitator of the "family therapy" that with the assistance of a professional therapist is able to resolve most dilemmas of internal conflict and personal distress.

Therapists have also used the family therapy version of traditional Kongo healing to deal with the epidemic of personal violence and rape that has been used by military forces in recent wars in Central Africa. Dr. Sidoni Matakot-Mianzenza, educational and clinical psychologist, has researched and worked to restore victims of violence, especially women who have experienced rape in the wars of the 1990s in Congo Brazzaville. In her therapeutic work she uses a combination of psychotherapy and traditional family therapy.[22] This was identified in earlier scholarship as "kinship therapy."[23] Women who experienced rape, according to Matakot-Mianzenza's experience, responded best to the embrace of their own extended family or clan along with positive counseling. Sometimes this was accompanied by recourse to *banganga* or *bangunza* for exorcism and further protection from witchcraft. The persistent recourse in Kongo society to therapies or rituals designed to protect the individual from harm, to reintegrate or reconcile individuals within the kin group, suggest that many people in the Kongo, Western Central African region, expect this kind of therapeutic or ritual attention to help them deal with their traumas.

Another area of dramatic juxtaposition of scientific insight and social planning is the recourse to genetic testing to determine if a betrothed couple risks the fate of serial loss of young children as a result of them being homozygous sicklers. Growing in popularity particularly in circles of the educated elite, the process has seen a ripple effect into popular consciousness. Sickle cell anemia, or *Drepanocytose*, affects many people in Western Equatorial Africa. Sickle cell anemia is a hereditary condition given by the heterozygous gene carrying father and mother (both with A/S) to some of their children. The statistical chances of such parents transmitting the condition to their offspring is 25 percent for A/A (non carrier, non sickler), 50 percent A/S (carrier, and potential transmitter, but with a sickling condition that gives some immunity against malaria), and 25 percent S/S (full blown sickler, susceptible to anemia and other crises, usually early death if not carefully managed; no cure available). Thus the offspring have a one in four chance of being S/S. In the Western Congo –DRC—fully 30 percent of the population is A/S.[24]

Dr. Joswe Mbaku**,** professor of psychology of the *Université Libre de Luozi*, specializes in public health awareness about sickle cell anemia. In a pamphlet that he distributes to any and all persons in his entourage and classes, he explains the symptoms and life chances of those

affected. Dr. Mbaku's tract offers the following treatment: at home, the pain of attacks may be diminished by keeping in well ventilated areas, with stable temperature; frequent drinking of water, eating a good and varied diet, avoiding strenuous exercise. Medical treatments include very expensive drugs; blood transfusions may be necessary in certain cases. The tract concludes by emphasizing that a long life is possible for S/S sicklers and that their parents should be encouraged to put and keep them in school. They have a future in occupations that do not require strenuous physical activity such as some professions, for example. Psychological counseling and moral support are very important elements of leading a reasonably normal life as a sickler.

But the perhaps greater impact of this rising consciousness of the genetics of sickle cell anemia and the sickling gene is in the way it has affected marriage politics and clan alliance negotiations, and the fates of the youths who fall in love and wish to marry. Before there was any consciousness of sickling as a hereditary condition, the serial deaths of young children that is the most telling consequence upon families were usually thought to be caused by an unfinished, inadequately paid-up, bride price, or witchcraft envy of the parents or close kin. The importance of the alliance bond between families was so great that failure to do it adequately brought to the fore undercurrents of miserliness and jealousy that were thought to cause sterility or children dying. As awareness grew of the nature of the condition, through public health education, it took the form of a vague sense that something was amiss in the biological makeup of the parents. But without an adequate understanding of genetics, this awareness was limited to identifying certain families, or kin groups, as somehow flawed resulting in their children dying.[25]

With more schooling, especially in the biological sciences, and with the training of many lab technicians and the advent of numerous Congolese medical doctors and nurses, a fuller comprehension of sickle cell anemia has emerged in Kongo society, and in this wider region of Africa so heavily affected by malaria. Today genetic testing is becoming a prerequisite for an acceptable marriage negotiation. If the couple are both discovered to be A/S, or have survived to marriageable age as S/S, medical counselors and psychologists routinely advise them to break off their engagement and find other partners. This introduces a whole new source of tensions. Those who refuse to break off their engagement are asked to sign a document informing them of the likely consequences and that they fully understand what they are confronting.

The emergence into public consciousness of a genetically transmitted condition as severe and life changing as the S gene, introduces new issues of identity, life choices, and moral considerations. Tampering with God-created nature or having to break off a cherished relationship may require a new kind of moral framework. Furthermore, to complicate matters even more, medical researchers suggest that there are multiple alleles (an allele is one of two or more alternative forms of a gene that arise by mutation and are found at the same place on a chromosome) in the genetic picture and that more refined testing can demonstrate gradations of severity in sickling ranging from extremely likely problems to less severe problems.[26] The consciousness of a sickling propensity introduces the kinds of ambiguities that have been confronted in genetic testing for other fetal defects. Science and spirit are so intertwined here that a sophisticated moral and emotional compass is required at each stage of this complex condition.

Causality and Personhood

Within the broad cultural field of misfortunes, a distinction is made in Kongo thought, and much more widely in Central and Western Africa, between those misfortunes that are "of God," (*kimbevo kia Nzambi*) and those that are "of man" (*kimbevo kia muuntu*). The first is a sickness that is in the natural order of things, or just happens. The second is caused by human ignorance, an unfortunate verbal assault made in a fit of anger, or in the worst case, intentionally caused physical or mystical harm to do deliberate injury through misfortune or sickness. The second corresponds to the very widely-distributed presence of the proto-Bantu verb *kuloka*, or *lok*, the power of words, or *dok*, the one from whom such words emanate. Clearly, the nature of the therapy sought will differ depending on which of the causes, or combination of causes cited here, is considered to have been in play. If an individual suffers a malaria attack with no attending suspected human cause, a visit to the hospital or clinic is in order, and the straight-forward theory of the spirochete carried by the anopheles mosquito will apply. If the episode passes with treatment, then the case was confirmed to be "God-caused." If, however, the patient relapses or the disease becomes chronic or issues of conflict surround the case, either suspected or confirmed by evidence or divination, then the clinical treatment may be complimented by a further investigation—*fiela, fimpa*—of possible human issues that are in play in the life of the afflicted. As research on extended cases in the Manianga revealed years ago, there may be a shifting etiological understanding within the therapy managing group or network, including the individual sufferer, or amongst a group of common sufferers. That is, a case or affliction that at one phase may be agreed to be "human-caused" may at another point come to be seen as "of God" if new evidence emerges.[27]

Clinical, theological, and cultural explanations have been given for this causal logic that entertains a wider field than the individual, and invisible agents as well as scientific empiricism. My scholarly interest in personhood in Kongo therapeutic logic was aroused first when I tried to make sense of *nganga nkisi* Nzoamambu's medical cosmology. The diagnostic gloss "*kimbevo kia muu*ntu" (sickness of man) corresponded in his dynamic scheme to a sequence of ever more severe reactions of the heart: palpitations, wild beating, "fear in the heart," "madness." Such signs in a sufferer, especially if demonstrated sequentially over time, were evidence of "something else going on." This entire model I called Nzoamambu's "theory of the person."[28] But this theory of the person is more widespread than one clever twentieth century *nganga nkisi*. It resonates in more widespread writing and practice in Central Africa and beyond. Within Kongo history, MacGaffey has summed up his understanding of the power of *min'kisi* as "the personhood of objects."[29] The *nkisi* mirrors the entire scope of relations of the *nganga*, the client, and the "other" of threatened aggression, society and nature. These relations combine metonymic and metaphoric allusions, as well as artistry in the harnessing of unique styles and surprises. In any event, the person in Kongo thinking and living is often different, more expansive and complex, than the post-Enlightenment Cartesian Christian bounded autonomous individual of current Western psychological and medical construction.[30]

The contours of this unique Kongo, Western Equatorial African, personhood include a number of aspects of identity, rights, and believed associations. There are the rights at birth to one's mother's lineage, its land, other privileges and obligations, focused on the relationship to one's *nkazi*, maternal uncle, who holds proprietary rights over his sister's children. An

individual also holds deep ties to father and father's kindred that are associated with intellectual and spiritual powers. A kind of bilateral identity ensues that has within it networks with other individuals and roles. The identity of every individual harbors the alliances sealed by bride price payments by father's kin to mother's kin, and the reciprocal gestures, including blessings that flow along the social channel of such alliances. Yet the individual is still in some sense original and autonomous. Names, for example, are independent of these lineage/clan associations, and may be changed by life course transitions or personal whim.[31] But it is this wider fan of kin, alliances, business and political associations, and echoes to the natural world that is invoked when suspicions of "something else going on" are raised in connection with sickness or other misfortune.

Healing the Whole Person: Biomedicine Joins *Kingunza*

The young doctor Bakima Luyobisa, who passed his medical school exams recently in Kinshasa, is also an accomplished and dedicated *ngunza*, prophet. We met him in Boma and he gave us a tour of the *Hôpital Général de Reference* where he is interning for a year, doing specializations of pediatrics, surgery, and internal medicine. On Sunday morning he was wearing another white gown, that of the *Communauté du Saint Esprit en Afrique*, with white hat and long cloth with the wide belt characteristic of this church's uniform. On the table of the single room he shared with three other interns there were several thick medical texts or manuals. At the Sunday service he had a KiKongo Bible and hymnbook. In the Bible were the notes of a course he had taken on traditional African healing. I had only suspected his full immersion in two so different healing traditions, but conversations with him indicated how he integrated the two in his thinking, his persona, and his career. Just as he was now a diploma-holding medical intern, so he was qualified to practice all the rites of the CSEA: the blessing, the healing, the *dumuna* weighing of the spirit. After completing his secondary school in the scientific track, with a specialization in chemistry and biology, he had taken his medical training at the Faculty of Human Medicine of the Simon Kimbangu University in Kinshasa, with his graduate license in medicine in June 2013. He had chosen this university not for its spiritual teaching or healing—which he said they do not teach—but for its high quality professors and well-equipped laboratories.

Bakima emphasized how different the two healing traditions are. Biomedicine offers a narrow focus on a disease and its treatment or on the function of particular organs. One learns the properties of medicines, how to apply them, as we saw on Sunday afternoon when he accompanied us to a pharmacy in Boma and prescribed two antibiotics for Mrs. Janzen's incipient urinary tract infection. Spiritual healing addresses the whole person in context, and offers assurance, contact with the Holy Spirit, protection, and harmony. There is a condition for its efficacy, however. One needs to believe in it. His training and practice was very much Christian, with reference to the life of Christ, the power of the Holy Spirit in healing. However in his knowledge of African healing he spoke of its herbal and shamanic dimensions. He also said that many of the CSEA rites and practices were distinctly Kongo in nature, and were rooted in the work of prophets as early as Dona Beatriz Kimpa Vita in the eighteenth century and other well known later prophets.[32]

Because they are so different, the two traditions of biomedicine and spiritual healing are complimentary. They fit together in his perspective, and to a degree in his practice. Many

patients he deals with expect treatment for their whole person, even if it is only a word of encouragement and hope for their suffering. When sick, Kongo patients seek understanding of the source of an illness and the hope of a counterforce to oppose or treat the condition, and to protect them. He said that "we young physicians" are experimenting with ways to offer a more complete healing at our hospitals and clinics.

We discussed whether spiritual healing might lead to wrong ideas about the scientific knowledge of diseases. He discounted this, pointing out that there is a big difference between ignorance or lack of knowledge of diseases, and spiritual healing. Spiritual healing is all about the whole person's well-being in life's circumstances, and receiving the benediction of a spirit-filled affirmation from the healer, family, and community. Since the CSEA practices healing, they claim that they remove the nefarious influence of bad spirits (by the healer circling the patient in a clockwise direction) and reinforcing good spirit (by circling in a counterclockwise direction), and through counseling.

We discussed the controversial practice of the examination of relationships and individuals who might be at cause in a sickness. He reiterated that the CSEA's policy prohibits this. One of their senior prophets told me that doing *kufiela* is beyond the domain of religion. Yet the healer has to know what is going on in the life of a sufferer, but does not have to reveal it. Other prophets in this tradition, or in the prophetic tradition in general, however, have done this, what the *banganga ngombo* used to do, and the few that are around still do, and many people demand to know. The *mfiedulu* process presupposes the power of anger and ill will upon the health of persons. So the CSEA allows for the reality of witchcraft, anger, and other negative emotions, and they heal and bless people so affected. But they do not officially dig around in such matters, nor help with vengeance seeking that used to be done by *banganga nkisi*, and may still occur. But they do bring the Holy Spirit in to protect such people, and to give them succor.

Finally, I asked Bakima if he could see himself opening a clinic with "spiritual healing and biomedicine" as its announced practice. In theory, yes. But the main hurdles would be the licensing aspect, to get governmental acceptance. Some of his colleagues among the "young doctors" look askance at his dual interest, but there are other young physicians in Congo who share this passion for treating the whole person by combining biomedicine and spiritual healing.

Conclusions

This presentation has yielded a number of broader observations about the direction of health and healing in Kongo society. On a whole series of fronts scientific knowledge is supplanting earlier popular understandings and the expertise of the *banganga*. But in many instances the manner in which this new knowledge is used and prioritized is done in the interest of reinforcing even deeper Kongo social and moral values.

Biochemistry, pharmacology, genetics, and evolutionary biology have become central in the treatment of major diseases and adaptive conditions such as malaria. This is extended to the understanding of the sickling gene and why there is increased pressure on betrothed couples to seek genetic counseling to determine if they are both A/S heterozygous, in which case they should separate. This measure emphasizes the importance of the deep Kongo value of viable

reproductive alliances and the desire to avert the child death syndrome that sickling is now understood to produce.

The broader, more inclusive, more widely-connected, personhood of Kongo thought and society harbors suppositions about the fates and fortunes in which "of God" and "human-caused" etiologies co-exist. This explains the manner in which God, the ancestors, nature spirits, and other individuals sometimes taking the form of animals, may occupy the same space as more narrowly-focused scientific theorems.

The gradual realization on the part of ritualists, psycho- and socio-therapists, of a more relational personhood in many Kongo settings, acknowledges a more inclusive social structure, and a keen appreciation of the importance of the protective aura around the person, and the critical role it is believed to play in health and well-being.

Western/global research and academic disciplinary perspectives in the hands of Kongo or Congolese activists embrace and try to reconstitute traditional Kongo instituted practices and perspectives—e.g., the *psychopalabre* or psychodrama integrating psychoanalytic "group therapy" with Kongo *nsamu/lukongolo* family therapy; Miatokot's clinical psychologically reconstituted "kinship therapy" for women's war trauma. Batangu Mpesa's pharmaceutical products drawn from *banganga* plant knowledge are subjected to laboratory testing, and interpreted through evolutionary hypotheses to withstand drug resistance tendencies of mosquitoes and spirochetes.

The story of health and healing in the Kongo region of Western Equatorial Africa illustrates the distinctive shape of knowledge in a unique and unfolding historical pattern of the human community, set in a particular—and challenging-- environment to which that human community is continually adapting.

Notes

1 For the 1960s fieldwork, see for example, Janzen 1978.

2 I am indebted to the following individuals for having assisted in developing and administering this questionnaire The Social Reproduction of Health / *La reproduction sociale de la santé* / *Mtombuka a zungu mu mavimpi*: Professor Dianzungu for translating my English statement of the project and letter of introduction into French and KiKongo; Mbuta Luyobisa Jackson for translating the questionnaire from French into KiKongo, and for administering it to many of the households after we tested it and conducted a number together; Ndiongono kwa Nzambi Marceline for assisting in the composition of supplementary questions on family planning, for translating this into KiKongo, and for administering this supplemental part to women in the sample of eighteen to forty-five years of age.

3 Ngemba Jeanbenoit, a community health activist, nurse-infirmier Mansinsa Dianzenza Delvin, and secretary Mbasani Veronique provided important and detailed information on the work of the Luozi Health Zone, one of three in the Territory, of three hundred in the entire Democratic Republic of the Congo. Dr. Alfred Monameso of the Protestant Medical Organization (CEC) provided important information on the operation of the Luozi Health

Zone; he shared the CEC's Vision 2017: Plan Strategique 2013-2017.

4 The research project "The Social Reproduction of Health in Lower Congo" was generously supporting by a Senior Research Scholar Fellowship from the Fulbright Foundation of the International Institute of Education.

5 An initial listing of names will not do justice to all the persons who helped. Diallo Lukwamusu provided intellectual reflection and logistical assistance whenever needed; Celestin Lusiama provided ethnographic assistance at times, and offered good conversation on many topics that came up; Thomas Kisolokele was my social conscience, etiquette adviser, mediator in a range of contacts I wished to make, and general conversationalist; Mama Jacqueline was our household host, chef, overseer, and gate-keeper, with ready and firm guidance on every occasion; Pierre Mayimona was our genius of a chauffeur-mechanic who not only kept our Hillux running and drove us all over from Kinshasa to Boma, and northward to Nsundi-Lutete, but was our bodyguard in those moments when that was needed.

6 Author's 2013 research in Luozi and wider archival and anecdotal information.

7 Although numerous historians and demographers have sought to establish accurate population figures for the Kongo region prior to the twentieth century, most published accounts of conditions before 1930 are estimates only until actual demographic studies in the 1930s. See Sautter 1966 and Trolli and Dupuy 1933.

8 A more nuanced reconstruction of population in the entire KiKongo-speaking region would need to recognize the distinctive patterns of Portuguese, Free State, Belgian, and French colonial policies and practices. This paper is mainly based on the middle region along the Congo River.

9 Listing from Luozi Health Zone 2002-2013, Maladies principales; the Janzen study intensive sample.

10 Kapita Bila 1988, cited in Iliffe 2006, pp. 12, 67-68, 97.

11 See Janzen 1978, chapter 10, featuring Nzoamambu's anatomy, cosmology, and herbaria, and his theory of the person.

12 Simon Kimbangu emerged as a prophet in 1921 in his home community of Nkamba west of Thysville (today Mbanza Ngungu), and for several months eluded the colonial authorities. Thousands of pilgrims like Katula came to see and hear him, drawn by reports of miracles. He was finally arrested and spent a lifetime in prison in Elizabethville (Lubumbashi). In the 1950s, his followers, many of whom spent their lifetimes in internal exile, returned and brought his mortal remains to Nkamba (-Jerusalem) to establish a holy city around his tomb, and the headquarters of the Church of Jesus Christ on Earth by the Prophet Simon Kimbangu. The church is a major presence in Congo and the wider region, with many congregations, schools, a university in Kinshasa, social services, and a significant economic and political presence. For an insider-European view see Martin 1976; and an anthropological perspective within the context of historical Kongo prophetism, see MacGaffey 1983.

13 See Janzen 1982, pp. 86-7, 90, 187-200.

14 Janzen 1978, p. 51, Plates 7, 8, 9.
15 See Janzen 2012, pp. 123-24.
16 Batangu-Mpesa 2009.
17 Kukunda's working style is covered in Janzen 1978 pp. 107-11.
18 Territoire de Luozi 2008, pp. 30-33.
19 See Janzen 1978 pp. 203-09; the grand *lukutukunu* gathering shown on Plate 18.
20 Interviewed by University of Kansas graduate student Heather Aldersey during her research in 2012 on disability support networks in Kinshasa.
21 Interviewed by Heather Aldersey 2012; also, Devey 2007. http://www.congoforum.be/fr/interviewdetail.asp?id=24420&interviewselected (last accessed 4/29/14).
22 Matokot-Mianzenza 2003.
23 Janzen 1978.
24 Mbaku n.d.
25 Historian Kimpianga Mahaniah has written a history of his own lineage, with dense S/S frequency, that was formerly accused of harboring witchcraft its midst, occasioning anger, estrangement, and poison ordeals. In an entire chapter devoted to this he seeks to explain the genetics of sickling to a KiKongo readership. Kimpianga Mahaniah 2001, pp. 54-56.
26 An allele is one of two or more alternative forms of a gene that arise by mutation and are found at the same place on a chromosome.
27 Janzen 1978.
28 Janzen 1978, pp. 169 ff.
29 MacGaffey 2000. pp. 78 ff.
30 For other applications of the notion of personhood in Central Africa see discussions of war trauma in Janzen and Janzen 2000, pp. 203 ff. For further elaboration of the notion of personhood in the history of Western thought and medical anthropology, see Janzen 2002 pp. 137-48.
31 Janzen 2002, p. 141.
32 For Dona Beatriz Kimpa Vita, see Thornton 1998.

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