

African Religions

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The inherited language of healing in eastern and central Africa presents an immediate paradox to those who would study the zone of interaction between science and religion. In many of the societies where Bantu languages are spoken (all across the center and the south of the continent), people have long made a distinction between illnesses of God and illnesses brought by other agents—often by humans, who are seen as having complex, ambiguous, and sometimes negative motives. The surprise here is that the term “illness of God” is used to refer to illnesses that happen without any moral cause—that just happen. People with university educations, whether in Africa or in the north, would say that these happen “naturally.” So, illnesses of God happen naturally, without a moral cause, while “illnesses of man,” or “of person,” or illnesses brought by the ancestors or other agents are seen as being defined, in a deep and powerful way, by moral relations. Illnesses brought by anger, by aggression, or by violations of the proper order by which human bodies, plants, animals, the wind, the rain, lightning, and all the other material elements interact—these are deeply moral and therefore the antithesis of illnesses of God.¹

The focus on health as an illustration of the larger field of knowledge, the cosmos, and the moral order—or science and religion—may be justified for several reasons. The debates of scholars over whether science, as we know it in the modern West, is even a part of historic African civilizations reflects widely diverging opinions, ranging from those who argue that “science,” as a form of knowledge production that originated in the West, does not map neatly onto distinctively African ways of producing knowledge—e.g., Paulin Hountondji, V. Y. Mudimbe, Kwame Gyekye²—to those who seek to reclaim bodies of technology and theory destroyed by colonialism, or to reconstruct ethnoscience or ethnophilosophy—e.g., Cheikh Anta Diop, Placide Tempels.³ These debates are complex beyond the scope of this essay. Many scholars, however, recognize the sophisticated knowledge and practices

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found in many African civilizations. Medicine and healing are usually at the forefront of those discussions, as suggested recently by Kai Kresse, a scholar of Swahili thought: "healing is a good example of a wide-ranging systematic field of knowledge-oriented practices that are performed in everyday life but also derive from coherent epistemologies, which in turn are linked to regional cosmologies and religions."⁴ Medicine is the research focus of the present co-authors, and so we focus on this realm to explore the contours of practical knowledge in central and eastern African societies in general. Other fields could as easily be examined.

The therapeutic practices of this region have changed drastically, as we will see, and are changing with increasing velocity. The twentieth century saw the slow and fitful introduction of European-style medicine by government hospitals and dispensaries (thus expanding the therapeutic possibilities for illnesses of God). Christian missionary physicians and nurses added another set of possibilities, sometimes aimed at undermining what they saw as the enchanted (or, in their language, superstitious) therapeutic world of ancestors and other spiritual agents—an attempt to secularize their patients before resacralizing their world in a Christian key. Other missionaries combined healing with Christian prayer from the start. In many places, Africans founded churches based on their own principles. Sometimes these churches reintegrated moral causes of illness, in the sense of the inherited categories, along with a modified Christian theology. Other syncretic churches prohibited any kind of therapeutic action outside the church—whether in government hospitals or by traditional healers. In these cases only religion in its purest form has had the capacity to heal. Still other religious movements introduced new varieties of therapy through dance accompanied by symbolic action—building in new ways on inherited forms—with the intention of reconfiguring relationships among people, and between people and spiritual forces, all with the goal of healing the sick.

All of these initiatives, whether by missionaries, by practitioners of *ngoma* (healing) dance therapy (see p. 238), or by the bishops of new churches—all of them had to come to terms, in some way, with the ideas embedded in inherited practice: that chronic and serious illness is both natural and moral at the same time. Such illness exists in both the world of material substances (in the body of the sick person and the efficacy of herbs) and in the world of relations among people or between people and spirit-agents. In most difficult illnesses (that is, in cases that were *not* illnesses of God), the practitioner needed to intervene simultaneously and in intertwined (perhaps integrally melded) ways with both sick bodies and moral relations, with herbs and with spirits, with symptoms and with personal quarrels. So, we have treatment of the body and its symptoms in a way that is inseparable from a set of actions that, in the United States, would be some

combination of three elements: treatment in an internist's office, family therapy, and religious ritual.

Our discussion will be limited to the societies of eastern, central, and southern Africa where Bantu languages are genealogically related; the discussion is limited also to interactions that involve both the region's older, inherited religions and Christianity. Defining our subject in this way may seem unnecessarily restrictive, but in fact the subject matter is audaciously broad. It takes in regularities underlying societies where five or six hundred separate languages are spoken, and where several hundred million people occupy a land area as large as Europe and China combined. A synthesis over this huge area is possible because the languages are closely related to one another—as closely related as the Romance languages—and because the very fact that the languages are both so numerous and so deeply similar in vocabulary and syntax gives the specialized methodologies of historical linguistics great power. It is possible to study widely distributed cognate words that are inherited from common ancestral languages in order to identify classical verbal concepts. These, then, when elucidated with the help of comparative ethnography, suggest well-developed ancient structures of knowledge and society. For example, the root *-ganga*, for doctor or specialist, is pervasive across the Bantu-speaking world that extends from Cameroon to Tanzania and down to South Africa. Related to the verb *-vanga*, to make or do, it applies to all manner of specialists, both in the healing arts and beyond. Thus, in Western Bantu, *nganga mbuki* is a "doctor of medicine," *nganga nkisi*, a doctor of consecrated medicines (see p. 235), *nganga lufu*, a "doctor of the forge," or blacksmith, master of a highly revered specialty in the knowledge of iron smelting and forging. Catholic priests are called *Banganga Nzambi*, "doctors of God." The head of a Mungano guild of snake handlers would be called an *mganga Mungano*, doctor of Mungano. Throughout the wider region it is possible to trace verbal concepts and related nouns at the basis of cultural practices, social institutions, and technical inventions and their distribution.

As we have suggested, and as the further illustrations will detail, the notion that African knowledge in the pre-colonial centuries blended empirical discovery with moral legitimation (ancestors, spirits, priests) is pervasive. Sharp opposition of science and religion as we know it in the organization of these fields in the modern university is a reflection of post-Enlightenment assumptions that thoroughly secularize specialized scientific knowledge. Sub-Saharan African history of knowledge should prove very instructive in grasping the character of a way of apprehending the world that while it fosters knowledge for a variety of practical ends, is open to the continuous interaction between visible and invisible, worldly and sacralized realms.⁵

We sketch several examples from pre-colonial, colonial, and post-colonial African history to demonstrate this. The pre-colonial period ended early in small parts of southern Africa but continued in most of tropical Africa up to the 1880s, when Europeans formally partitioned the continent into colonial spheres, which began as markings on a map, to be occupied over several decades. The colonial era ended in the early 1960s, when most colonies gained independence, although some remained under white control or were engulfed in wars of independence for several decades more. "Post-colonial" is both a time period, following colonialism, and a set of political and cultural conditions among independent nation-states, which to varying degrees continue to experience (and struggle to change) colonial administrative and economic structures, along with languages, and attitudes that shape all aspects of life.

RITUALIZED IRON SMELTING IN UFIPA AND THE GREAT LAKES REGION

The integration of science and the spirits, the idea of technical actions that have a powerful symbolic valence, is an ancient one in the region of the Bantu languages. Historical archeologists have found the same kind of integration in their work on iron smelting in the regions near Lakes Victoria and Nyasa. The process of refining iron was one of great technical complexity, since it involved combining ore with charcoal under conditions that carefully controlled the flow of oxygen in order to reduce the ore by chemical action. Near Lake Victoria, the particular tree used in making the charcoal was rich in calcium and potassium, thus serving as a minor flux (a substance mixed with a metal to facilitate its fusion). Carefully chosen grasses were added to the furnace, and the grass char served to remove oxygen from the iron oxides, promoting the formation of an iron bloom through both chemical and mechanical processes. Similar grasses were found in very old furnaces near Lake Nyasa, showing (along with much other evidence) that the process is not a new one. These technical elements were integrated with symbolic-social ones, in a way that is similar to the therapeutic process. The efficacy of technical acts depended on the moral context in which they were performed. The furnace itself was shaped like the womb of a pregnant woman; air flow was controlled by its passage through phallic tuyeres (earthen nozzles entering the bottom of the furnace). The grasses and the species of charcoal tree had great symbolic significance. And the production process only worked if the men who worked at the furnace abstained from sex. In other words, the womb-furnace would produce its iron only if placed in the correct symbolic-moral-spiritual context.

The medical domain was similar. Healers were serious in their treatment of the technical side of healing the sick—they were careful, for example, in their choice and preparation of herbs. But herbal medicines in the wrong social and moral context stood as much chance of healing the sick person as the furnace did of producing iron when the smiths had violated the rule of abstinence.⁶

CENTRAL AFRICAN SHRINES AND RITUALLY DIRECTED ECOSYSTEMS

A similar emphasis on moral and symbolic ways of constituting technical acts can be found in many of the shrines of central Africa. Father Matthew Schoffeleers, a Catholic priest and distinguished anthropologist, has spoken of a "ritually-directed eco-system."⁷ Shrine authorities, whose role might superficially be seen simply as arranging ritual forms of mediation between spiritual agents and those who attended the shrine, also sometimes had the job of regulating land use: of deciding when a field ought to be left fallow, when a stream ought to be closed to fishing, or when a particular agricultural practice was harmful to the fertility of the land. At the Bunda shrine, in central Malawi, the agents of the shrine had control over the process of burning old and dried-out vegetation, which was central to the preparation of the soil for a new farming season. The process of burning was technically complex. Colonial agricultural researchers took decades before they fully understood its significance. In Zambia, where a form of burning called *citemene* was practiced, agricultural officers found that "the fertilizing effects of ash were clearly important, but other things were happening when a citemene field was burned . . . the phosphate and potash status of the soil were enhanced by burning, and . . . freshly burnt soil also contained a high concentration of calcium that improved its physical condition. . . . Furthermore, burning appeared to have increased soil acidity, which meant that the added phosphates could be more easily maintained."⁸ In Mozambique, a British naturalist found that control of disease-bearing insect pests depended on the timing and intensity of burning—something that could be achieved, in a coordinated way, only by either shrine authorities or political leaders. Once again, as with the healing of individual bodies (which also took place at some of the same shrines), we have a seamless integration of technical, moral, social, and symbolic acts. Not all of technical knowledge was integrated into such a domain. Just as people suffered from illnesses of God—illnesses that just happened, to be treated by herbs that just worked, with no shrine mediator or traditional healer—so farmers knew many techniques that just worked, in a pure (and rich) domain of practical knowledge.

Given these forms of social action, it is difficult to isolate a set of relations or beliefs that map, in some easy, predictable, and legible way, onto the domain of religion. Historians of religion tend to look for beliefs, and yet the healing practices and shrine practices, the ways of healing by reordering relations between the living and the ancestors, or the forms of therapeutic dance that brought people into a relationship with spirits, or the words spoken over chemically active grasses when they were put into an iron furnace—none of these actions came with explicit articles of faith. Words spoken to the grasses, songs sung at shrines, the gestures a healer makes when treating a patient, all can be read by scholarly analysts as implying certain relationships between humans and spirits, implying that the spirit world, approached in this way, has certain regularities. But the person doing the reading is the scholarly analyst. It is not a credo recited by a believer, nor is it a catechism to instruct, and measure the faithful obedience of, adherents.

Looking for beliefs in this context is problematic and vexed for a different reason. Rodney Needham, the British anthropologist, wrote a book addressed to the question of whether belief is an experience.⁹ His exploration of the complexities and ambiguities of the word "belief" make it clear that the act of interpreting non-European practices in terms of belief is a profoundly problematic strategy—one that short-circuits more nuanced explorations of the ideas and assumptions embedded in ritual practice and the associated discourse, whether in African or European contexts.

The world of medicine, and more generally of knowledge for technical ends, presents an additional set of problems for anyone who wishes to isolate a domain of religion, or a set of generally accepted spiritual ideas, in the varied settings of the world where Bantu languages were spoken. It is that many varieties of knowledge are socially constituted. In societies with either no literacy, or very limited literacy, but with great quantities of technical, social, and aesthetic knowledge, complex bodies of knowledge were preserved, reproduced, and put into use by being divided among many holders. In many cases, the people who held knowledge were also interested participants in a process of political or social negotiation. For example, in the pre-colonial period in what is now Malawi, people resorted to the shrine of the Mbona spirit to deal with problems of epidemic, drought, and large-scale threats to survival and reproduction. The shrine house was itself a medicine-object, and it needed to be rebuilt at moments of great public crisis. But it could only be rebuilt through a process of political collaboration. Every major holder of political authority or influence in the region around the shrine needed to participate in the process of construction. Without this political collaboration, the parts would never fit together, and the shrine would lack efficacy.¹⁰ In the Lower Congo region near the Atlantic Ocean, the objects known as *min'kisi*, used for healing illness (among other things),

were seen as lacking in life until endowed with power through a complex process of social composition. In the most complex of these, a major ritual needed to be performed if the object was to be endowed with power. This involved many different holders of knowledge and many different performers of ritual and practical action. People could not endow the objects with power without the spirits, but these could never be addressed except through the correct social process, which was also one in which specialized participants assembled knowledge that was otherwise divided and fragmented.¹¹

This process of composing a medicine was a social negotiation, a way of addressing the spirits, a technical act, and an aesthetic performance, all at the same time. To insist on defining a distinct and bounded domain of religion, and another one of science, is under these circumstances counter-productive.

TREATING BODY PAINS IN WESTERN BANTU

In Western Bantu languages spoken along the western equatorial coast (from Cameroon to Angola), and inland from there, technosocial knowledge and problem solving crystallized, historically, around *min'kisi* (singular, *nkisi*). A range of historical evidence indicates that *min'kisi* have been part of this region's therapeutic landscape for at least a millennium, perhaps two. One of the present authors, Janzen, has at times defined the *nkisi* as a consecrated medicine, but this definition (like all simple definitions of this complex phenomenon) is inadequate. The concept needs to be unpacked piece by piece if it is to be understood.

Not all medicines are called *min'kisi*. An *nkisi* is the product of an interaction between the relevant substances or objects on the one hand and, on the other, a specialist with therapeutic or transformative capacities—that is, by an *nganga*. A simple plant that has not been treated, or invoked, or composed by an *nganga* is not an *nkisi*. Plants, whether treated or not, are called *minti* (trees or bushes) or *makaya* (leaves). A more general term for medicine is *bilongo*—natural ingredients that have been combined or treated in some way, though not necessarily by an *nganga*. The term *bilongo* includes combinations of plants compounded together, bottles of ointments, pills, injections, and other hospital medicines. What differentiates the *nkisi* from other medicines is not the ingredients but the relationship to the *nganga* and to the moment when the *nkisi*'s efficacy was brought into being.

Each *nkisi* has a remembered moment of origin, a charter that is necessary in signifying its efficacy and the nature of its powers. Each *nkisi*, each consecrated medicine, originated at some time in the past in an individual

vision or in a relationship between an individual and a spiritual entity. The *nkisi*'s defining elements were fixed at that original moment of creation. These elements include recipes of ingredients (*bilongo*), techniques of composition and use, the songs, dances, and words without which its power would not exist, and the prohibitions that define proper and improper behavior for the person who operates the *nkisi* and the one who is treated with it. Generally, an *nkisi*'s ingredients were held in a container of some kind: a bag, a gourd, a sculpture, or a basket.

An *nkisi* is too "hot" to be handled by laymen. At the moment of origin it was properly handled by the ancestor who had invented it, and then by the *nganga* to whom it came through a chain of transmission, and who then taught it to an apprentice. If the *nganga* is to use it properly, he or she must be inaugurated in a relationship with the *nkisi*. Without this inauguration, without the proper relationship, the *nkisi* is dangerous and could cause madness.

If we look back at the history of *min'kisi*, we see that some appeared at moments of general societal crisis, moments when people felt that core social values were threatened. They were also used (and still are) for treating individual physical illness, like a stomach ache, or for an emotional, social, and spiritual crisis in an individual's life.

Min'kisi must be "composed" if they are to be effective—if they are to be living *min'kisi* and not simply inert objects. The act of composition may be modest, as when an individual *nganga* combines herbal medicines and invokes their power, or they can be enormously complex, involving a great many people. Massive ritual organizations—large-scale associations that played a practical role in regulating markets and organizing politics—could also have as their central purpose the composition of an *nkisi*. One such large association was Lemba, an association that existed in western equatorial Africa from the seventeenth century on. The characteristic way to join such an association was to become ill: one needed to be initiated in order to be healed. People's careers as individuals suffering from affliction, and as healers, progressed in a seamlessly unified way. Each act of initiation into a more responsible level in the association was also a therapeutic act meant to treat an illness. The large-scale rituals in which people came together, with drumming and dancing, were also, at the same time, the actual act of composing an *nkisi* and giving it efficacy. In the case of Lemba, which thrived at the time of the trade in slaves, in copper, and in ivory, the healing association also provided some elements of public security. Senior *banganga* kept peace at marketplaces, even in locations where no centralized political authority was able to guarantee security. People whose kinship groups were weak, or who were cut off from relatives altogether, could have a "mother" or "father" in Lemba.

Min'kisi are, thus, not one simple kind of object, but a whole rich world of objects that can act effectively on individual bodies and on social situations, the only irreducible requirements being that they must be composed (*handa*) and that each one needs to have some kind of relationship to an *nganga*. The history of the past 450 years is thus a complex story of a great many different *min'kisi* and of many different varieties of *banganga*. Different kinds of specialists have come into fashion, and gone out of it, over the years. Lemba, for example, no longer exists today. Over centuries, the main gatekeepers to the diverse universe of *banganga* were the diviners called *banganga Ngombo*. These days their role has diminished, and prophets play a more central gatekeeping role. Some *banganga* have been narrowly specialized, like cupping-horn users, who appear to have been a constant over centuries, or the *nganga lunga*, who deals with conditions of the bones, the *nganga mpu*, who inaugurates a chief, the *nganga mukoko*, who cures women's infertility, the *nganga mpansu*, who deals with mental illness, and so forth. Others are generalists; the *nganga nkisi* is supposed to know about all medicines. The inventory, over those 450 years of recorded history, is stunningly rich.

Any one variety of *nkisi* might also change over time. *Nkisi Makongo*, for example, appears in documentation over three centuries as a main treatment for *lubanzi*, literally "side," or "stitch-in-the-side."¹² The condition appears not just in the side but in the neck and shoulder area. It corresponds to what we might call tension in the back, shoulder, or neck, or to headache. *Nkisi Makongo* has not been exactly the same thing over the three centuries for which we have records. In the 1960s and 1970s, when Janzen was doing field research, patients and their caregivers sometimes explained it in terms of organic symptoms ("pneumonia," "crossing of the ribs," "bad blood") and sometimes in terms of interpersonal aggression or tension (and in this case not to be treated in hospitals or clinics). In the early twentieth century (and also earlier), *Nkisi Makongo* was represented by a statue of a human. Today, *Makongo* figures are found in museums, with wedges and nails driven into the shoulders, sides, and neck, each one for a case that was treated by the *nganga* who owned the *Makongo* statue. Each iron wedge is thus a vivid memento of pain, aggression, and treatment.

By the 1960s, *Makongo* statues no longer played any role in the treatment of *lubanzi*. At that time, discussions of *lubanzi* between *banganga* and Janzen revealed a subtle logic of diagnosis and treatment, of a kind that may have existed earlier but is difficult to perceive by simply looking at the statues and reading the sources. *Banganga* saw the process of treatment and diagnosis as unfolding over time. They began by treating the physical symptoms, through massage and tranquilizing medicines to remove the pain or the stitch. If these treatments worked, it was confirmed that the case was

merely physiological. Sometimes even a hospital treatment worked for the disease, if it did not involve some form of human aggression. If treatments of the symptoms did not work, the failure led to the conclusion that some sort of human conflict was involved. The stages of treatment echoed the progression of the disease. *Lubanzi* was seen as progressing from superficial causes (involving muscles and joints), which might be addressed directly, to internal ones, affecting the heart as a moral-emotional center, and the very being of the individual. If *lubanzi* was not treated early—if its progression was not arrested—then the illness might go on to be destructive of the heart, taken as the self, and might lead ultimately to madness, perhaps to death.

We have already seen in the case of Lemba that it was possible for people to create an *nkisi* that had an ongoing life as a form of collective action—a life that was more than the sum of individual treatments. *Min'kisi* of this kind were characterized by the people of the region as “drums” (in Kongo, *ngoma*, *nkonko*, or *n'konzi*). In the Kongo way of seeing things, “drums” are a particular form taken by corporate groups, the members of which come together for periodic ceremonies, whereas simpler *min'kisi* are the focus of treatments that draw people together on an ad hoc basis. “Drums” are also a large-scale collective process by which *min'kisi* are composed. “Drums” are multifunctional, whereas a standard *nkisi* has only a single function. Most important of all, the “drum” took on an institutional life of its own. It had a continuing group membership, with its own forms of recruitment, the purpose of which was to achieve individual and collective health.

The name or central characteristic of the “drum” related to a particular mode of affliction, and membership consisted of fellow sufferers with this common affliction who, in drawing together, produced 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—were considered best suited to become specialized *banganga* of the ailment for which the drum was known. Sickness was often seen as a sacred calling, manifested as possession by a spirit of a former drum member. If the possessing sickness was placated, the disease brought under control, recovery at once purified and energized the individual, placing him in debt to the group, which henceforth expected him to consecrate his newly found gifts as medium in this specialized domain to the service of others. The ingenious quality of the historic, fully incorporated drum is that it reproduced a set of intellectual and performative understandings of disease; it presented those who were afflicted with the support necessary for sustaining treatment and with support in the more general tasks of life.

The healing associations, or “drums,” as ongoing institutions based on shared affliction and mutual support, still exist today over wide areas of the Bantu-speaking region, although in many places they now coexist with (or have in some cases been supplanted by) healing churches that have many of the same characteristics: group identity, recruitment through affliction, an emphasis on mutual support, and an ongoing purpose in individual and collective health.

The Kongo (and, more widely, western equatorial African) vision of health that stood behind the continuum of medicines has been expertly formulated by Mahaniah.¹³ We have seen that it included (and still includes) individual plants (*nti*, *makaya*), compounded medicines (*bilongo*), consecrated medicines and actions (*min'kisi*), and, at the largest collective level, corporate therapeutic associations (*ngoma*, or *nkonko*). When sickness occurred, community members were mobilized to find a rapid and effective solution, including above all the reestablishment of the subject's equilibrium. This treatment aimed to purify the community and, with the return of harmony, to guarantee general well-being. These practices, at once religious and medical, were seen as an intervention involving supernatural forces and natural processes, all bound up together. Thus, to treat a sufferer was not only to reestablish his physical normality but also to re-create 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.

The western equatorial African *nkisi* thus played a substantial social role, sometimes alongside political authority, in centralized kingdoms or chiefdoms. In modern states, it served sometimes as a source of public order in the absence of sovereign centralization, and sometimes (in relation to states) as a place where alternative social visions—a semi-autonomous sphere of critique—have been located. The *nkisi's* role was, at one and the same time, technical and moral, political and intimately personal; it was related to productive technologies like iron working and forms of environmental control in agriculture and hunting, and was capable of dealing with moral threats, like aggression and infertility, and with broad social change (like the overseas mercantile trade of the seventeenth century). Partly because of its capacity for carving out a partially autonomous political sphere, and partly because its vision of the world mapped partially (and however imperfectly) onto Western conceptions of religion, *min'kisi* came under attack in the colonial period. Colonialism's moral agents (missionaries) and its power brokers (colonial officials), along with the dictates of the head tax and forced labor, overwhelmed this system of knowledge. Anything having to do with *min'kisi* and operated by *banganga* was branded as heathen and superstitious and was attacked, uprooted, defamed. We will see how the

West's categories of religion and science (especially medicine) were imposed upon a more integrated African civilization—one whose functional domains of knowledge differed from European ones.

COLONIAL MISSIONARIES AND "MIDDLE FIGURES"

A separate domain of religion certainly exists in Africa today, but this was, to a very considerable extent, created through an interaction between Africans and missionaries, through complex processes, in many different places and many different ways. At the same time, missionaries struggled to define an appropriate role for medicine, as a secular European science within a Christian tradition of healing. Terence Ranger describes the "medical modernization" undertaken by the Universities' Mission to Central Africa (today Tanzania) as an all-out initiative to provide scientific education for African dispensers and nurses as a means of counteracting indigenous practices.¹⁴ The missionaries were joined in this effort to create new domains of "science" and "religion" by African lay evangelists, teachers, nurses, auxiliary medical workers, and (in some places) even priests. Historians of Africa have come increasingly to appreciate the crucial role played by these people, often defined as "middle figures," in Nancy Hunt's term.¹⁵ People in these positions were fully grounded in their own African societies and had an intuitive understanding of local social practices that Europeans could never achieve, yet they also had an understanding of European goals and ways of doing things. These middle figures were often devoted, in their own right, to the propagation of Western medicine and the Christian religion, but they understood how to advance these goals in ways very different from missionary approaches.

For Africans subjected to proselytization in the early colonial period, conversion did not mean the simple acceptance of one set of religious beliefs or practices in place of another, nor was it only a matter of re-mapping conceptual or functional domains (making religion something distinct from therapeutics). In the central highlands of Kenya, when the Gikuyu came to engage with European missionaries and missionary doctors, they needed first to relate to a network of social relations, spirits, and objects in a new and different way—to disentangle themselves from old relationships, to deal more frequently with objects that needed to be treated as though they were inert. What in Kongo would have been called "dead" *min'kisi*—that is, *min'kisi* that had not been activated by ritual performance, mere objects that did not have the power to transform human bodies, lives, and relationships—these dead things were said by missionaries to have the power to cure. Gikuyu were subjected to a cultural regime in which individuals needed to

become disentangled from the social webs in which knowledge was preserved and selfhood, health, and illness defined. It is for this reason (the need to disentangle) that the first converts in eastern Africa were usually people who had been cut off from their families. Missionaries worked to transform subjectivity through the construction of villages of square-cornered houses, in rows (in place of round ones in clusters), and through the introduction of clocks so that the day's work and prayer could be coordinated through the mechanical management of time. "Structuring the mundane in time and space thus helped define the subjective, personal space of belief."¹⁶

Meanwhile, the missionaries worked, as they saw it, to unearth (in part, actually, to invent) a Gikuyu conception of God, so as to constitute a religion with belief at its center. The historian who has worked to interpret the words and meaningful gestures of Gikuyu of that period explains that in the period before conquest Ngai, "God," was neither the cause nor the cure of most illnesses, which were entangled in relationships at a more intimate level. Every now and then people sacrificed to Ngai when misfortune struck on a scale that was too large to be controlled by ordinary methods of reordering relationships among people or between people and ancestors. At the wider environmental boundary between the dynamic wilderness on the one hand and land controlled by fluidly interacting social groups on the other, people were forced to gamble, to take a chance on Ngai. A broad famine or epidemic proved that ordinary means of control did not work, and so people were compelled to roll the dice—to make a gesture to Ngai. Missionaries interpreted these dynamic and contingent gestures to Ngai as a timeless form of worship—one expressive of belief. One missionary reported a conversation, in 1911, in which people argued that speaking of Ngai would make them sad, for this was a subject about which people thought when rains fail or when "people are in sorrow or pain."¹⁷

Derek Peterson, the historian who has studied this process most closely among Gikuyu, explains:

Missionaries sought to turn Gikuyu social praxis toward the atemporal categories of ritual and religion. By representing creative, dangerous practices as timeless ceremonies, by dividing up human activities with clocks and fences, by judging human actions with immutable laws, missionaries worked to create a mechanical world, a society governed by rules. . . . The textualization of social life, the rendering of process into religious ritual and law, was as much a colonization of Gikuyu society as were the great moments of military conquest.¹⁸

Peterson and Paul Landau (in this case writing about people in early colonial Botswana) both argue that missionary medical practices were a part of this deeper conversion of subjectivity. According to Landau,

Tswana specialists in healing (*dingaka*, a cognate of *banganga*) immersed themselves in those experiential relationships that, epitomized by the ancestors, *defined and united persons within their community*. In contrast, . . . missionaries' therapeutic practice tended to *disrupt this prior community* and substitute for it the idea of the individual as enclosing the relevant field of sickness/wellness.¹⁹

In Botswana, missionary healers of the early twentieth century learned to speak of the body in mechanical terms, of digestion as a "manufacturing plant" and the heart as a "force pump," and this, too, served to locate illness in the individual body (consisting of quasi-mechanical parts). This strategy did not, however, constitute a thoroughgoing attempt to secularize medicine, since illness was linked to sin and healing to God's mercy. The result was, however, a transformation of older African ideas about links between illness and impropriety or hurtfulness. The key change was that the sinner, as described by the missionaries, was an individual, extracted from his or her community, whereas older practices placed the broad web of relationships at the heart of both illness and therapy.²⁰ We have already seen that this process of individualization, and of making objects (even parts of the body) seem inert and mechanical, was also necessary if people were to begin speaking with missionaries about individual belief as a basis for religion.

Christian medical treatment as extraction from community was, however, only a transitional moment. Both Landau and William Tuesday Kalusa (writing about Mwinilunga District, in Zambia) describe how converts worked with great energy to create therapeutic Christian communities within mission churches. In Botswana *baruti*, African evangelists, introduced group prayer for illness and "dealt with troubled or sick people as members of the Christian *community*," in a way that had not been a part of missionary practice.²¹ Zambian Christians did much the same thing. All-night collective prayer vigils for the sick became a part of Christian practice in both places. Today in Mwinilunga, group prayer has been integrated into mission hospital practice as an essential ingredient immediately before a patient is treated. In other words, in Zambia, Botswana, and many other places, African patients were extracted from their communities but then later chose to integrate themselves into new kinds of healing communities. The people who were crucial in this creative process were the middle figures: the African evangelists, nurses, and teachers who had a rich understanding of both missionary practice and practice within their own local communities and who therefore had the necessary knowledge for creating novel social forms.²²

The process by which missionaries defined a domain of religion, revolving as it did around questions of belief, also had the effect of separating out—placing in a very different category—those aspects of inherited

therapeutics that deal with spiritual beings. We have seen that among the Kongo, as in many parts of the Bantu-speaking region, *min'kisi* are powerful, in part, because of their links to the ancestors who first created them. The centrality of community relations in older forms of healing—the necessity to cure the patient by reordering his or her social relations—was not limited to relationships with the living. The effective community includes also family members who have died. The dead comprise another, more distant, class of elders. In some languages, the word for ancestor is identical to the word for a living elder.²³ We can see, in this case, that a therapeutic intervention that addresses the patient's body, while reordering his or her network of social relations, necessarily involves both the living and the dead.

When European observers, missionaries, and administrators separated out therapeutic relations from social ones, they also, at the same time, created a world of African religion separate from the therapeutic or technological practices that had always been in an integral, undifferentiated relationship with the ancestors and other spiritual beings. The politics of African resistance in the early colonial period guaranteed that this new split between healing and religion would be a sharp one—an enormous gulf separating aspects of what had been either a single phenomenon or perhaps a tightly focused cluster of related phenomena.

European conquerors, during the first two decades of colonial rule, faced enormous rebellions by Africans who saw European rule as a threat to their own reproduction and survival. Europeans, puzzled by the coordination of political and military action on a huge scale, across lines of language and culture, focused on the role of public healers: people who specialized in therapy, in actions to increase fertility and well-being, but who did not limit themselves to individual illnesses, instead treating armies, chiefdoms, and whole territories. The great uprising in 1895–96 that almost drove the British and South Africans from what is now Zimbabwe, the similarly powerful threat posed to German East Africa by the Maji Maji Rebellion of 1905–7, and the uprisings in the name of Nyabingi in western Uganda all provoked similar responses among Europeans. The colonizers emphasized the roles of spirit mediums, shrine priests, and other similar leaders. The region's new rulers characterized these leaders as practitioners of irrational religions (of "witchcraft") and passed laws making everything these people did illegal. In the relevant Tanzanian ordinance, for example, the definition of the punishable offense included "the purported possession of any occult power."²⁴ What had been integrated practices—for treating bodies and the body politic, for dealing with material-technical substances and with the ancestors—now fragmented, with missionaries and Muslim leaders taking care of the domain of "religion" and local-level traditional healers, along with a few scattered hospitals and dispensaries, representing "medicine." Medicine

and religion are therefore, in their current forms, the creations of colonial-period crises and transformations.

POST-COLONIAL INTEGRATED AFRICAN COSMOLOGIES

In this section we consider post-colonial scholars, practitioners, educational administrators, scientists, and therapists who strive to integrate something of the ancestral holistic cosmology with biomedical knowledge and cosmopolitan professionalism. They provide a fascinating commentary within a larger scientific-religious field with many different points of view. Priests in mainline churches, professionals educated to a secondary or university level, and many others often adopt an approach similar to the North American or Western European one: that science and religion are at one level rigorously separate domains, while at another level we all struggle with zones of tension and interpenetration. In the medical fields, most hospitals across the continent enforce policies that rigorously exclude the practice of traditional medicine, while some integrate Christian (or Muslim) prayer into their daily routines. Beyond this, a small minority of Christian churches—a subset of those whose principles and practice have been reinvented locally—exclude both biomedicine and traditional medicine and rely exclusively on healing through community prayer and through the charisma of church leaders.

A very interesting and important set of intellectuals, scattered across many countries, reflect on this larger scene and respond by attempting to forge an original and characteristically African synthesis of science and religion. The scholars quoted early in this essay have emphasized that any attempt to reconnect historic knowledge with modern science in Africa must be part of universal science in order to be credible. The issues at stake in such a reconnecting are ably sketched by the contemporary Ghanaian philosopher Kwame Gyekye, who has studied the history of the relationship of thought, technology, and religion in pre-colonial and post-colonial Africa.²⁵ Gyekye asks, from his post-colonial point of view, how the African sciences can be brought into harmony with Western science. Generally, in his remarks, he notes the extensive and original developments of African agriculture, medicine, and various technologies, all rooted in empirical innovations and adaptations. What has generally been missing in the pre-colonial tradition when seen from the point of view of Western science, in Gyekye's account, is the emergence of scientific theory that builds knowledge for its own sake and allows for the variety of abstract reasoning characteristic of modern science. He points out that the prevalence of secrecy in African traditional knowledge is a hindrance to such scientific development. While

acknowledging the rich empirical observations and practical techniques of African arts, Gyekye suggests that the tendency to ascribe knowledge to spiritual agents must be dealt with in order to reconcile this knowledge with the hallmarks of modern science, namely experimentation and sustained investigation.²⁶ We will review a number of contemporary African scholars, practitioners, and administrators who seek to reconcile universal science with African medicinal traditions.

The late Rwandan scholar and physician Pierre-Claver Rwangabo offers an insight into contemporary African thinking on illness causation. 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.²⁷ He divides medicine into "physical" and "mystical" causes. Diseases range across a variety of types that 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*) often 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.

Byamungu lua Lufungula is a Congolese pharmacist with a medicinal factory in Bukavu and pharmacies in Uvira and Goma. He works with healers, and in this region of extensive pastoralism some of these healers are veterinarians. He has adapted African materia medica, making them commercially saleable. In his scholarship he has also studied the healing cults of the region; thus his interests cover a broad therapeutic spectrum, from herbal medicines to spirit possession cults. Does his emulation of the West's secular pharmaceutical approach to healers' medicines compromise the integrated character of this knowledge? His French training in pharmacy gives his pharmaceutical inventions scientific legitimacy, yet his writing and work with healers anchors him in a broader integrated cosmology.

Philip Guma is one of the new South Africa-educated elites who integrates the traditional knowledge of the initiated (*sangoma*, *igqira*) as well as Western university education. He teaches at the University of the Western Cape in Cape Town. His doctoral research explored the relationship of childhood malnutrition and the well-being of the soul of a child in the eyes of mothers, nurses, and healers in Khayelitsha, South Africa.²⁸ Guma's study deals with the social interpretation of childhood diarrhea among the Xhosa-speaking people of the Western Cape. It highlights how in this area political consciousness and moralist discourses strongly influence relationships between different health care systems and the production of continuing conflicts around problems of health care delivery. It argues that if meaningful relationships can be found between older African social health-seeking strategies and biomedical classifications of enteric and other diseases of women and children, they could facilitate the provision of more equitable, effective, and widely acceptable health care.

Furthermore, Guma's study compares the etiological explanations of childhood illness signs and symptoms adopted by non-elite mothers and by health practitioners of two kinds: professional nurses trained in biomedicine, and indigenous African health practitioners (IHPs). The comparison focuses particularly on the interpretation of stool quality and associated symptoms. For stool quality the study refers to the color and texture of children's feces that mothers and health practitioners identify and associate with distinctive conditions of affliction. There is variation, even ambiguity, in the interpretation of commonly understood illness categories and with respect to diarrheal illnesses. Knowledge remains contested between mothers and professional nurses. Moreover, the availability of a wide range of therapeutic options in Khayelitsha diversifies the mother's causal explanations. It was found this diversity in causality and management of illnesses is manifested in the quality of children's stools, "green" feces in particular. Their interpretations draw on senses of value, ideas, social histories, different forms of power, systematic knowledge, and a great variety of other forms of significance that are embedded in the concrete domains of everyday life. In addition to the notion of *isuntu* (that is, humaneness), the study more importantly reveals that among Nguni of the Western Cape a tripartite relationship of *umoya* (vital force), *inyongo* (gallbladder), and *ithongo* (ancestral dream) is the dynamic philosophical component that describes Nguni experiences of health and illness.

Sidonie Matokot-Mianzenza is a trained psychotherapist in Brazzaville who has tried to come to terms with the dark side of modern warfare, in particular the use of sexual violence as a weapon.²⁹ She worked with many women and girls who had been raped and impregnated by strangers during Brazzaville's civil war of the 1990s. She found that the most effective way of

dealing with these traumas was through traditional kin therapy supported by both older women and female peers, with the approval of male elders who had the capacity to legitimize the women's actions. It is clear from historical records concerning kinship therapy all across eastern and central Africa that healers and families have long had effective and carefully structured methods for reintegrating, and embracing, people who are deeply wounded and who, without this therapy, might be treated as morally inferior. Matokot-Mianzenza's book concludes with a discussion of whether the relationship of traditional therapy to Western psychotherapy is "competitive" or "complementary."

One of the most remarkable post-colonial synthesizers was the university founder and scholar Kimpianga Mahaniah, of Luozi, Lower Congo, Democratic Republic of Congo. The Université Libre de Luozi (ULL) is one of several dozen new universities in the DRC that either grew up out of the rubble of the National University or arose as altogether new creations.³⁰ These new universities are decidedly local efforts, the work of loyal and determined supporters—teachers, landowners, merchants, churches—often with the support of national and foreign nongovernmental organizations. Although Mahaniah lives and works in his home community, his education is solidly cosmopolitan, in Protestant mission schools of Lower Congo and at Temple University in Philadelphia, where he received his Ph.D. in history. The ULL, under Mahaniah's direction, has concentrated on agriculture, commerce, development, and the environment. Outreach has also played an important role in this university through the Centre de Vulgarisation Agricole, which stages short-term conferences and publishes relevant pamphlets and books on the work of the university.³¹ Mahaniah's own research on the history of Christianity in the region seeks to integrate the historical place of missions with ancestral religion and practical knowledge.³² Yet in the early twenty-first century the ULL has a decidedly practical aspect to it, rooted at one and the same time in the sciences, in up-to-date electronic technology, and also in local ecological knowledge about ancestral lands and other assets that must be protected for future generations. One reaches Luozi best by small aircraft—or by the Internet. Once there, one can enjoy the ambiance of an African village or retreat to a forest preserve that features the herbarium of trees and medicinal plants.

These Western-trained African scholars and practitioners, all of whom bridge the science/religion continuum, emphasize the context of the causal attribution that 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 as a phenomenon 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. The first realm we might term "natural," the second "unnatural." But this very recognizably African way of thinking requires closer examination so that we do not simply read into it the influences of Western thinking.

The African scholarly universe appears to be open to acceptance of religion and science in the same framework, all the while many African scientists adhere to the Western separation of science from religion. It would appear that the moral and humanistic envelope of knowledge that integrates science and religion may well be a genuine contribution of African tradition to the world community.

Notes

1. Feierman's research shows that people in Lushoto District, in northeastern Tanzania, make this distinction in the Shambaa language. See also John Janzen, *Quest for Therapy in Lower Zaire* (Berkeley: University of California Press, 1978), 8; and Wyatt MacGaffey, *Art and Healing of the Bakongo Commented by Themselves* (Bloomington: Indiana University Press, 1991), 9. For the same distinction in Malawi, among Tumbuka, see Steve Friedson, *Dancing Prophets: Musical Experience in Tumbuka Healing* (Chicago: University of Chicago Press, 1996), 40–42.
2. Paulin J. Hountondji, *African Philosophy: Myth and Reality* (Bloomington: Indiana University Press, 1983), 98–100; V. Y. Mudimbe, *The Invention of Africa: Gnosis, Philosophy, and the Order of Knowledge* (Bloomington: Indiana University Press, 1988), xi; Kwame Gyekye, "Philosophy, Culture, and Technology in the Postcolonial," in *Postcolonial African Philosophy: A Critical Review*, ed. Emmanuel Chukwudi Eze, 25–44 (Oxford: Blackwell, 1997).
3. Cheikh Anta Diop, *Towards the African Renaissance: Essays in African Culture and Development, 1946–1960* (London: Karnak House, 1996); Placide Tempels, *Bantu Philosophy* (Paris: Presence Africaine, 1959).
4. Kai Kresse, "Knowledge: An Overview," *New Encyclopedia of Africa*, vol. 3, ed. John Middleton and Joe Miller, 152 (New York: Charles Scribner's Sons, 2008). As if acceding to the view that this African knowledge is not science, the *New Encyclopedia of Africa*, as the latest word among scholars of Africa, carries no entry on science.
5. See, e.g., the Dwight Harrington Terry Foundation's lecture series on Religion in the Light of Science and Philosophy, which recently included Mary Douglas's *Thinking in Circles: An Essay on Ring Composition*, (New Haven, Conn.: Yale University Press, 2007). The invocation reads: "... [not the simple] promotion of scientific investigation and discovery, but rather the assimilation and interpretation of that which has been or shall be hereafter discovered, and its application to human welfare, especially by the building of the truths of science and philosophy into the structure of a broadened and purified religion."

6. Bertram Baltasar Mapunda, "An Archaeological View of the History and Variation of Ironworking in Southwestern Tanzania" (Ph.D. diss., University of Florida, 1995); Peter R. Schmidt, *Iron Technology in East Africa* (Bloomington: University of Indiana Press, 1997), 58, 60, 76, 81, 86, 90, 93, 94, 115, 121, 216–21, 225, 227, 228. See also Eugenia W. Herbert, *Iron, Gender, and Power: Ritual Transformation in African Societies* (Bloomington: Indiana University Press, 1993).
7. Matthew Schoffeleers, ed., *Guardians of the Land: Essays on Central African Territorial Cults* (Gwelo: Mambo Press, 1979), Introduction, 3. Feierman does not fully agree with the idea that this was a ritually directed ecosystem, since many of the elements of control came from commonly accepted knowledge and only some were imposed by ritual authorities. But this idea is nevertheless a useful one.
8. On the Bunda shrine, see Schoffeleers, *Guardians*, 3; Matthew Schoffeleers, "The Religious Significance of Bush Fires in Malawi," *Cahiers des religions africaines* 5 (1969), 271–82. See also Henrietta L. Moore and Megan Vaughan, *Cutting Down Trees: Gender, Nutrition, and Agricultural Change in the Northern Province of Zambia, 1890–1990* (Portsmouth, N.H.: Heinemann, 1994), 28–30.
9. Rodney Needham, *Belief, Language, and Experience* (Oxford: Blackwell, 1972).
10. Matthew Schoffeleers, *River of Blood: The Genesis of a Martyr Cult in Southern Malawi, c. A.D. 1600* (Madison: University of Wisconsin Press, 1992), 6ff.; Matthew Schoffeleers, "The Story of a Scapegoat King in Rural Malawi," in *The Quest for Fruition through Ngoma: Political Aspects of Healing in Southern Africa*, ed. Rijk van Dijk, Ria Reis, and Maria Spierenburg, 99–116 (Oxford: James Currey, 2000). For a detailed and explicit example of social composition, see Steven Feierman, "On Socially Composed Knowledge: Reconstructing a Shambaa Royal Ritual," in *In Search of a Nation: Histories of Authority and Dissidence in Tanzania*, ed. Gregory Maddox and James Giblin (London: James Currey, 2005). For an early article on social composition, see Jane Guyer and Samuel M. Eno Belinga, "Wealth in People as Wealth in Knowledge: Accumulation and Composition in Equatorial Africa," *Journal of African History* 36 (1995): 91–120.
11. Wyatt MacGaffey, ed., *Art and Healing of the Bakongo* (Stockholm: Folkens Museum–Etnografiska), 95; John M. Janzen, *Lemba, 1650–1930: A Drum of Affliction in Africa and the New World* (New York: Garland, 1982); Wyatt MacGaffey, *Astonishment and Power* (Washington, D.C.: National Museum for African Art of the Smithsonian Institution, 1993); John M. Janzen and Wyatt MacGaffey, eds., *An Anthology of Kongo Religion: Primary Texts from Lower Zaire* (Lawrence: University of Kansas Publications in Anthropology, no. 5, 1974).
12. John M. Janzen, "Lubanzi: The History of a Kongo Disease," in *African Health and Healing Systems: Proceedings of a Symposium*, ed. P. Stanley Yoder, 107–19 (Los Angeles: Crossroads Press, 1982).
13. Kimpianga Mahaniah, *La Maladie et la Guérison en Milieu Kongo* (Kinshasa: Centre de Vulgarisation Agricole, 1982), 29.
14. Terence O. Ranger, "Godly Medicine: The Ambiguities of Medical Missions in Southeastern Tanzania, 1900–1945," 274, in *The Social Basis of Health and Healing in Africa*, ed. Steven Feierman and John M. Janzen, 256–82 (Berkeley: University of California Press, 1992).
15. Nancy Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, N.C.: Duke University Press, 1999).

16. Derek Peterson, "Gambling with God: Rethinking Religion in Colonial Central Kenya," in *The Invention of Religion: Rethinking Belief in Politics and History*, ed. Derek Peterson and Darren Walhof, 42 (New Brunswick, N.J.: Rutgers University Press, 2002). See also Jean Comaroff and John Comaroff, *Of Revelation and Revolution* (Chicago: University of Chicago Press, 1991), vol. 2, on missionaries' material practices as a way of transforming African ways of experiencing the social order and individual subjectivity.

17. Peterson, "Gambling with God," 46.

18. Ibid., 45.

19. Paul S. Landau, "Explaining Surgical Evangelism in Colonial Southern Africa: Teeth, Pain and Faith," *Journal of African History* 37 (1996): 263.

20. Paul S. Landau, *The Realm of the Word: Language, Gender, and Christianity in a Southern African Kingdom* (Portsmouth, N.H.: Heinemann, 1995), chap. 5. On mechanical parts, see 121.

21. Ibid., 127.

22. William Tuesday Kalusa, "Disease and the Making of Missionary Medicine in Colonial Northwestern Zambia: A Case Study of Mwinilunga District, 1902-1964" (Ph.D. diss., Johns Hopkins University, 2003), 207-8, 216; Landau, *Realm of the Word*, 129. The dental image of extraction from community is from Landau's account of Botswana, where early nonmedical missionaries pulled teeth as part of their daily activity; see Landau, "Explaining Surgical Evangelism."

23. Igor Kopytoff, "Ancestors as Elders in Africa," *Africa: Journal of the International African Institute* 41 (1971): 129-42.

24. Tanganyika Territory, "An ordinance to provide for the Punishment of Witchcraft and of Certain Acts connected therewith," Ordinance no. 33 of 1928, vol. 9, no. 61 (December 28, 1928), supplement 1, 157-60. This account is drawn from Steven Feierman, "Colonizers, Scholars, and the Creation of Invisible Histories," in *Beyond the Cultural Turn: New Directions in the Study of Society and Culture*, ed. Lynn Hunt and Victoria Bonnell (Berkeley: University of California Press, 1999). See also Steven Feierman, "Healing as Social Criticism in the Time of Colonial Conquest," *African Studies* (Johannesburg) 54 (1995): 73-88.

25. Gyekye, "Philosophy, Culture, and Technology," 25-44.

26. Ibid., 27.

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

28. Phillip Mthobeli Guma, *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* (Ph.D. diss., University of North Carolina at Chapel Hill, 1998).

29. Sidonie Matokot-Mianzenza, *Viol des femmes dans les conflits armés et thérapies familiales: Cas du Congo Brazzaville* (Paris: L'Harmattan, 2003).

30. http://www.nekongo.org/uni_luozi/index.htm

31. Bahelele K. Ndimisina, *Bingana bia Nsi Eto* [Proverbs and sayings of our country] (Kinshasa: Editions Centre de Vulgarisation Agricole, 1989), a re-edition of a popular work on deep tradition by a well-known Protestant pastor; Dianzungu dia Biniakunu, *Nsi Yankatu Ngongo Eto: Tuzolele Nsi Yalubutu, Yantoko ye Yicilumukanga Maza* [We reject the loss of our land: we claim a land that is fruitful, beautiful, and

springs with water] (Kinshasa: Editions Centre de Vulgarisation Agricole, 1987), an ecological consciousness-raising analysis and polemic by a well-known high school teacher and administrator.

32. Kimpianga Mahaniah, *L'Impact du Christianisme au Manianga, 1880-1980* (Kinshasa: Editions Centre de Vulgarisation Agricole, 1988); *La Maladie et la Guérison en Milieu Kongo* (Kinshasa: Editions Centre de Vulgarisation Agricole, 1982).