DIABETES, MEDICINE AND MODERNITY IN CAMEROON

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ABSTRACT

This article examines popular understandings of diabetes, and conflicts and ambiguities in the management of diabetes care, in two areas of Cameroon. Conducted over a two year period, comparative ethnography in Yaounde and Bafut started in four diabetes clinics (two in each place), and extended outwards to the homes of patients with diabetes, and then on to a number of indigenous healers consulted by those suffering from diabetes or their families. We explore here the tension between clinic demands for patients’ ‘compliance’ with treatment guidelines, including repeated strictures against resorting to ‘traditional’ medicine, and patients’ own willingness to alternate between biomedicine and indigenous practitioners, subjecting the claims of both to a kind of pragmatic evaluation. The continuing importance of indigenous healing practices, and explanations for diabetes in terms of ancestral intervention or witchcraft, are considered in the light of recent anthropological debate about the ‘modernity of witchcraft’ in Africa.
INTRODUCTION

The scene is a small rural hospital in northwest Cameroon. A few night staff remain on duty after their more senior colleagues have left. During the evening an indigenous healer arrives, invited by members of the family of a very ill diabetic patient. Nursing staff allow him in, and he proceeds to perform a ritual to diagnose the ‘true’ causes of this particular case of diabetes. The purpose of this intervention is not conceived of as calculated subversion of the hospital’s treatment, by either the family of the patient or indeed the healer. Instead, it is envisaged as a way to supplement hospital care with something more powerful and effective before it is too late for the fast-weakening patient. Afterwards, the healer is ushered out discreetly, and nobody present will allude to the incident in the days following. All concerned know that this is a consultation seriously breaching hospital codes of conduct, which is why it takes place surreptitiously, after the departure of those more senior staff who would forbid it. Yet equally, all concerned see themselves not as colluding in some kind of shameful wrongdoing, but simply as sharing the same widespread assumptions about illness, diagnosis and therapeutic possibilities. Their thinking and behaviour is ‘common sense’, pursued in some desperation because of the urgency of the patient’s deteriorating condition, yet driven ‘out of sight’ by the codes of conduct associated with the practice of biomedicine.1

We start with this example from fieldwork in Bafut, in the Grassfields of north-west Cameroon because it highlights vividly several key themes – just as apparent in urban as in rural areas – which we discuss in this analysis of conflicts and ambiguities in the management of diabetes. Crucial to our analysis is an unresolved tension between two approaches to health and the treatment of illness. On the one hand, the impulse of many patients – and their families – is commonly to combine forms of treatment in a manner that may be seen as pluralistic, a kind of therapeutic hybridity. As the illustration above suggests, less senior hospital staff may well subscribe to the same assumptions, even if they have to be extremely guarded in admitting to such views. On the other hand, articulating the public ethos of the clinic and of biomedicine, the rhetoric of doctors and more senior staff fiercely resists such medical pluralism, and the complementarity between therapeutic options which it implies. The need for patients’ ‘compliance’ is the watchword in this context, and the habitual failure of patients to comply properly with the advice and treatment they are given is the biggest headache for the more senior clinical staff. Yet non-compliance is a matter of degree, and there could be few actions more scandalously non-compliant than to invite the disparaged (but also slightly feared) figure of the indigenous healer to intrude on the sacrosanct space of the hospital.

Equally emblematic of the gulf between these two approaches is the goal of treatment in the case of diabetes. For the clinic or hospital, ‘compliance’ assumes such rhetorical importance because the fundamental message to patients and their families is that there is at present no possibility of curing diabetes (cf. De-Graft Aikins 2005; Mbanya and Mbanya 2003; Whiting et al 2003). It is instead a matter of learning to live with a condition which must be managed or controlled if it is not to lead to sudden deterioration and death. Compliance means the difference between living a largely ‘normal’ life with few symptoms, on the one hand, or the enduring danger of life-threatening complications, on the other. Diabetes thus demands sustained clinical surveillance and self-discipline for the rest of one’s life. For indigenous healers, and for many people with diabetes (or their families), such a prognosis is both a counsel of despair and also flies in the face of deeply ingrained beliefs. It is axiomatic, from their perspective, that illness and disease can be cured. Treatment is a path to recovery, not a life-sentence of disease management. If the clinic or hospital cannot cure diabetes it
highlights not merely the limitations of biomedicine, which its practitioners are regarded as reluctant to admit, but the vital importance of alternative knowledge and treatment procedures which can make good that deficiency and deliver the desired curative outcome.

This paper explores the ways in which individuals with diabetes, of both sexes, and their families negotiate these difficulties in Cameroon. In the process the analysis knits together the world of the clinic and the indigenous healer, even if the two spheres are rarely so visibly joined as in the instance with which we start this paper. While ‘traditional healing’ (we discuss the issue of appropriate terminology later) has long been a familiar staple of anthropological writing on Africa, little has so far been written by anthropologists about African clinic settings, or how these contrasting therapeutic approaches simultaneously figure in the choices and actions of patients or their families. One of our analytical aims is to explore through this ethnography the conundrums and misunderstandings which make the clinical rhetoric of ‘compliance’ strident, frustrated and often fruitless in Cameroon today. But considering the world of the indigenous healer also entails discussion of ritual forms of power, including those associated with the actions of witchcraft and ancestors. A second analytical aim is, in consequence, to contribute to recent debate in anthropology surrounding the modernity of ‘traditional’ healing practices. A considerable literature over the past decade and a half has taken as a starting point the sustained vitality of witchcraft discourses across sub-Saharan Africa. As we shall explore in more detail later, much of this literature has argued persuasively for the ‘modernity of witchcraft’ (Geschiere 1997), and the manner in which witchcraft beliefs, far from being supplanted by rapid social change, may be seen as assisting the practical negotiation of such change. Certain sceptics by contrast have stressed how witchcraft’s ubiquity (or what Green (2005) refers to as its normativity) does not lessen the fact that it carries distinctly ‘unmodern’ associations. This argument can be readily extended to indigenous healing generally, and has particular salience where diabetic patients seeking such treatment do so against the express advice of the clinics which have diagnosed their diabetes in the first place. The rhetorical tussle between the claims of biomedicine and indigenous medicine enacted in the lives of those diagnosed as diabetic thus forms the ethnographic heart of this account. But equally this same tussle also ensures that questions about what modernity means and entails in relation to health and medicine were far from being remote abstractions in the lives of those concerned.

BACKGROUND

The Cameroon context of research

Ethnographic fieldwork took place in two areas of Cameroon: in urban Biyem-Assi, an administrative district of Yaounde, the capital; and in Bafut, a rural district in the north-west of the country. Biyem-Assi is one of six health districts in the largely francophone capital, serving a population of over 400,000 from many different ethnic backgrounds through twenty-one formal medical facilities at the time of fieldwork (hospitals, health centres, and pharmacies, both public and private). Bafut has a highly dispersed population of around 75,000 served by ten such medical facilities, and is well known as one of a series of former kingdoms in the Bamenda Grassfields. The centre of the modern administrative district and traditional kingdom is the town of Bafut itself, and it was there that fieldwork took place. While there has as yet been little ethnographic writing on Yaounde, there is by contrast a considerable literature on the Bamenda Grassfields, starting with Kaberry’s colonial era research with Chilver (e.g. Kaberry 1952), and including more recently Diduk (1993), Fowler and Zeitlyn (1996), Feldman-Savelsberg (1999), Goheen (1996), Gufler (2003), and
Nyamnjoh (2001). Moreover, one ethnographic study with a similar interest in the ambiguities surrounding illness, diagnosis and treatment has also come from the Bamenda Grassfields, namely Pool’s (1994a) exploration of the gulf between indigenous and clinical understandings of what biomedicine labels kwashiorkor.

The primary aim of this research was to examine responses by patients and their families to clinical diagnosis of diabetes (specifically type two, or non-insulin dependent diabetes mellitus) in areas where some basic biomedical services for diabetes were already established, and thus some kind of response to diagnosis was possible. A secondary aim was to compare such responses in an urban and rural context. To this end, Paschal Awah undertook a year’s fieldwork in each setting, starting in Biyem-Assi, continuing in Bafut, and then returning to the city for a final brief supplementary spell. In both places, fieldwork started in clinical settings (two clinics in each place), and gradually ‘followed the patient’ home, and on to the alternative forms of treatment and healing that patients or their families sought. This fieldwork required the use of four languages - French, English, Pidgin and Bafut – of which Awah had to learn only the last for fieldwork.

The choice of Biyem-Assi and Bafut as urban and rural sites respectively, and of these particular clinics, was based purely on expedience. These four clinics were already involved in, and partly funded by, a public health programme of research on ‘non-communicable diseases’ led by Newcastle University (cf. Fezeu et al 2006). Moreover, Awah had previously been employed as a medical sociologist on this project. He thus had considerable prior knowledge of the clinics and the two settings, and was the more easily able to arrange the necessary access. On the other hand, and as might be expected, this new role as ethnographer was initially complicated as much as facilitated by that previous association: often introduced early on to patients by medical staff as a doctor, it was hardly surprising that, in Bafut especially, people sometimes expressed surprise at the range of Awah’s fieldwork enquiries with remarks such as ‘but I thought you were a diabetes doctor’. The point to stress here is that ethnographic research evolved out of that earlier public health programme. A large number of men and women with diabetes came within the compass of this research (eighty-two in total). However, the sample of nineteen patients selected at the start of the study (nine in Bafut, ten in Biyem-Assi) for regular follow-up, was identified through the clinics, and after discussion with a senior clinical figure in each clinic. It was not the intention to seek a formal random sample of diabetic patients on the books of each clinic, but to put together more opportunistically a sample representing a spectrum of diverse personal characteristics among those whom Awah met in each clinic, including both sexes and a mix of those recently diagnosed as well as those of longer standing. A crucial consideration was the willingness of patient and family to accept the long-term contact necessitated by regular follow-up meetings. At the risk of stating the obvious, those with undiagnosed diabetes could not be part of this study. Later on in the research, nine indigenous healers were also contacted and visited, four of them on several occasions. In all, over twenty such practitioners were interviewed singly or took part in focus groups in Yaounde and Bafut. All were men.

**Ethnographic perspectives on diabetes**

Diabetes is one of a number of chronic diseases of complex aetiology now becoming an ever more urgent public health issue in Cameroon, just as in every other country of sub-Saharan Africa (De-Graft Aikins 2005; Gill et al 1997; Mbanya and Mbanya 2003; Whiting et al 2003; Wild et al 2004). Epidemiologists have described diabetes as reaching ‘epidemic proportions’ in the developing world as much as in the wealthiest nations, with major consequences for health care budgets. For social scientists, alongside a more general interest
in delineating popular medical understandings of diabetes and associated illness narratives, particular attention has been given to the construction of ‘compliance’ as a clinical problem. Diabetes exemplifies those chronic medical conditions where the necessity for treatment for the remainder of life, coupled with frequent discrepancies between clinical indicators and patient symptoms, opens a space in which patient ‘compliance’ with treatment guidelines becomes a recurrent biomedical concern (Broom and Whittaker 2004; Conrad 1985; Hunt et al 1998; Hunt and Arar 2001).

Theoretically, studies by medical anthropologists and sociologists in the USA have drawn on Foucault to highlight an endlessly frustrated clinical effort to create the disciplined diabetic subject – a process promoted through the surveillance regime of regular clinical monitoring (Foucault 1973; also Ferzacca 2000; Montez and Karner 2005; Schoenberg et al 2005; Trostle 1988). That has relevance in the African context also, even though there is as yet virtually no comparable ethnography relating to diabetes (an exception is De-Graft Aikins’ study in Ghana (2005)), for the ubiquitous use of indigenous medicine alongside biomedicine accentuates the prominent place of ‘compliance’ in African public health discourse. Perhaps the most suggestive ethnography for understanding the rhetorical power of the language of ‘compliance’ is Ferzacca’s Healing the modern (2001), based on fieldwork in urban Java. His work explored medical pluralism in the treatment of diabetes, and the ways in which this helped to generate and exacerbate biomedical strictures about ‘compliance’. Two points in his illumination of the interpenetration of ‘traditional medicine’ and biomedicine are germane to our own argument. First, he challenges the construal of clinics as “entry sites into modernity where exposure to the hegemony of scientific medicine takes place” (2001: 69). Second, as the title of his book suggests, he stresses the analogy in popular discourse between the health consequences of modern life and general musing on the health of modernity (2001: 15). These are themes which will resonate in the ethnography which now follows, even where our conclusions diverge.

DIABETES CLINICS AND EXPECTATIONS OF ‘COMPLIANCE’

Diagnosis as ‘diabetic’ (the named condition) is the province of biomedicine and the clinic. But clinical diagnosis and treatment only scratches the surface of the problem, in various ways which we hope will become apparent. Diabetes – both the word and the medical condition – remains unfamiliar to many in Cameroon and commonly goes unrecognised. Most diabetes is therefore undiagnosed. Nevertheless, as the urgency of tackling diabetes has grown, so has public recognition of both the term itself and the health problems it signifies. To the extent that it is recognised, popular understanding tends to regard diabetes as a new or ‘modern’ disease, an assumption which clinic staff in both settings reinforced in their own explanations to patients. But that ‘modern’ label conceals uncertainty as to whether the disease itself is a modern occurrence, or only recognised through modern medicine, or a symptom of modern living (cf. Ferzacca 2001). Against this background, newly diagnosed patients could draw on little by way of common knowledge of what diabetes was and what it entailed, a problem compounded by a new and unfamiliar terminology.

Unsurprisingly, the term ‘diabetes’ does not straightforwardly match with the lexicon of ill-health in Cameroon’s main indigenous languages (cf. Pool 1994a, 1994b). To illustrate this through the more linguistically straightforward case of Bafut, two words, the indigenous fumbgwuang and English shugar, are most frequently used, often prefixed with nighoni (sickness, disease). Nighoni-shugar thus denotes ‘sugar diseases’ and nighoni-fumbgwuang
‘disease that is sweet’. Yet, *funggwuang* also refers to salt, indicating a taste that goes wider than the sweetness associated with sugar. The terms given by people reflected how the language of ‘high sugar level’ (hyperglycemia) in the clinic has found its way into popular idioms of ‘sweetness’. In both settings, many patients acknowledged that ‘diabetes was caused by eating a lot of sweet things’, identifying the significance of the food they ate and what they drank, and the changes in eating habits which have occurred over the last generation or so (De-Graft Aikins 2005). As awareness of the significance of the disease has grown, one relatively common form of self-diagnosis has been by tasting one’s own urine for the taste of *funggwuang*. Indeed, individuals who were already being treated for diabetes sometimes used this method to control their blood glucose levels, especially when they could not or would not do so in a clinic. Urine offered another clue also, for the swift arrival of ants where a person has urinated was also taken as a possible indication, as it was well known that ants were attracted by deposits of sugar or salt.

Attending a clinic for diabetes introduced a series of expectations and assumptions which formed the basis for future misunderstandings: notably around the nature of the disease, its complications, and the kind of diet that was advised or to be avoided. When a patient first attended one of the clinics chosen for this study, there began a process not only of tests but of education and instruction also. While the former was anticipated, the latter typically proved harder to accept. For the fundamental ‘message’ clinics sought to convey was that the symptoms labelled diabetes indicated a medical condition which could not be cured, and instead required careful monitoring and management for life. Alongside that, patients were made aware that diabetes had many associate problems: it increased the risk of high blood pressure, heart disease and stroke; it reduced libido; and without careful management kidney failure and blindness were possible complications. Furthermore, patients learned that diabetes aetiology combined both inherited and behavioural factors, in which what they ate and drank would have played a major contributory part, and that it was through regulating their diet in future that they had the best prospect of managing their diabetes successfully.

This process of instruction typically unfolded through successive consultations with clinic staff, usually nurses. The Etoug-Ebe Baptist Health Centre in Biyem-Assi was unusual in its more explicit procedure for underlining advice and encouraging group participation in question and discussion sessions. Both the Christian message and the primacy of compliance with clinic guidance were more forcefully stressed there than in the other clinics studied, and something of the flavour of the educational message provided is conveyed in the following extract from one of these talks by a senior nurse:

Bitter things! Some people think that eating bitter things helps to bring down glycaemia level in the blood. This is not true. Family history of diabetes predisposes and descendants will have it if preventive measures are not taken. You are at risk but it is not certain that you can be diabetic. Some people think that it is sexually transmitted. No! When you go to certain places like traditional healing homes they tell you that they treat diabetes. No! It is for life, and you have to control it. When a person is diagnosed and put on lifestyle measures, if he follows them strictly he might live without drugs. This does not mean that the person has been treated. He has been controlled. (16 November 2001)

Many attending this clinic did not stay for these talks and advice sessions, and even among those who did, senior staff realised that such information went over the heads of many. But in all of the clinics, even where the educational instruction was not so collectively organized nor so precisely articulated, an explicit task was seen as how to underline to patients that their
‘compliance’ was essential, if symptoms were to be controlled and complications avoided. The importance of compliance thus recurred constantly in discussion. What was not clarified so clearly, but would emerge over time, was that ‘compliance’ entailed several levels of conformity and self-discipline. First, it meant acceptance of a timetable of regular appointments at the clinic (though the Etoug-Ebe Health Centre was alone in emphasising a consciously disciplining style by fining patients who arrived late). These enabled the regime of monitoring of blood sugar level, blood pressure and weight to take place. Second, it meant acceptance of the need for self-monitoring of diet and changes to food and alcohol consumption. And third, perhaps above all it meant acceptance that the clinic itself, and the bio-medical approach, should remain the sole source of treatment, with the understanding that this was a chronic and incurable condition. The need to adhere to a bio-medical regime and no other, to ‘modern’ and not ‘traditional’ medicine, was a constant and explicit clinic refrain. How complicated the seemingly simple notion of ‘compliance’ would prove to be was something which was rarely apparent to patients immediately, as we tease out in the next section.

INTERPRETING INSTRUCTIONS: PATIENT AND FAMILY AMBIVALENCE

The most immediate trigger for accusations of non-compliance concerned apparent failures by patients to follow guidance about necessary changes to eating and drinking. This could be willingly acknowledged by those with diabetes in the common admission, ‘I’m cheating the doctor’. But while alcohol consumption was a particular source of clinic frustration, patients themselves were often genuinely confused about what was or was not safe to eat or drink. An understanding that diabetes involved excessive levels of sugar in the blood often encouraged those with the condition or their families deliberately to cut out what they saw as sugary food. Many knew also that beer contained sugar, and thus, like soft drinks, ought to be avoided. However, certain other alcoholic drinks were commonly seen as bitter, and the more bitter the taste the more they were construed as ‘safe’. In particular, the local palm wine was seen as bitter and therefore ‘safe’: as one Bafut man put it, ‘we are told not to drink this palmwine, but this palmwine is medicine to us’. Guinness likewise was bitter and seen as ‘safe’. Further, because Guinness Cameroon promoted its value in building strength, Guinness was often seen as virtually medicinal, a means to regain the strength to combat both diabetes and lost libido (not always recognized as associated), and thus doubly effective. Bitterness thus stood for good health for those with diabetes, in contrast with the sweetness which signified ill-health. What better way to neutralise excess sugar in the body than the bitterness of palm wine or Guinness? These arguments were put forward by both men and women, but more commonly by the former, and one, a patient in Biyem-Assi, put it like this: ‘When I come to this bar, I drink my Guinness and it makes me to feel strong. I have been told that it is good for diabetes patients because it is bitter’ (Biyem-Assi, 22 January 2002).

Because modification to habits of eating and drinking was emphasised by clinics as so vital, adjusting to the onset and diagnosis of the condition was more than a matter solely for the individual concerned. Household eating habits were likely to be affected, and given the social significance of commensality, that was no small matter. Some households saw the adjustments necessary as being relatively minor and easily made: ‘when we want to cook food at home we cook her soup differently and ours differently… at times, we cook food in the same pot, remove hers then add oil and salt in ours’ (family member, Biyem-Assi, 28 July 2001). But it was not always straightforward, and family tensions around dietary changes were distinctly gendered. Men with diabetes were more likely to resist the modifications their
wives or sometimes children sought to introduce; while women with diabetes were more likely to feel that their requests for the consideration of special dietary needs were disregarded, with the response that there was insufficient money. The contrast highlights the gendered nature of ‘compliance’, but also the wider financial burden associated with such conformity (cf. De-Graft Aikins 2005). Men’s command over household financial resources guaranteed diabetic men priority access to drugs, treatment and special food. Women with the condition typically had a much harder task in asserting an equivalent claim on household finances. And even where she had support from her family initially, sustaining it over the long term was another matter. Sources of tension and misunderstanding abounded therefore, not only between clinic and patient, but quite often between the latter and other members of their family.

Some of the commonest misgivings patients had about clinic guidance on diet concerned the desirability of weight loss and the significance of blood pressure. They and their families struggled to come to terms with the idea that diabetes patients should lose weight, when this was simultaneously seen as a kind of diminution or disfigurement. These concerns were compounded because of HIV/AIDS (De-Graft Aikins 2005). For dramatic weight loss now has particular connotations, accentuating resistance to it, for no-one wants to be thought to be losing weight because of AIDS. Losing weight was equated with ‘growing dry’, shrivelling up, the sexual connotations of such an eventuality being implicit in the larger misfortune. In the words of one man with diabetes, ‘I feel that I am a man when I am fat. When you start losing weight, people think that you have AIDS’. A family member echoed this view, even to the extent of asserting that ‘it is good he should die resembling a man than dying looking like somebody with AIDS’. Blood, its strength and its pressure, produced further mutual misunderstandings. Clinic monitoring entailed the routine checking of blood pressure, as we have seen, with constant advice about the dangers of high blood pressure. Yet the clinic’s language of high and low blood pressure easily got elided with popular understandings about ‘strong’ and ‘weak’ blood, frequently alluded to by indigenous healers. Attempts by clinics to lower blood pressure in patients with diabetes got portrayed as tantamount to ‘weakening’ the blood, construed to be a highly undesirable state signifying greater bodily vulnerability to harm of many kinds.

But it was the duration of diabetes, its chronic character, which in the final analysis made ‘compliance’ so hard for patients. For a period, adhering to a clinic regime may be manageable and financially feasible, perhaps even the preferred option (cf. De-Graft Aikins 2005). Sustaining this course was the hard part, especially if financial hardship became greater, or cultural expectations among men about the conviviality of shared drinking proved increasingly hard to resist, or weight loss (for either sex) provoked unwelcome gossip and rumour. Moreover, over time, as complications of diabetes arose, many patients tended to deal with these as distinct illnesses, rather than as causally connected with the diabetes. The extract below illustrates the mutual frustration when a longstanding diabetic patient believed that the doctor was ignoring her ‘real’ health problems, which she reckoned were no longer to do with diabetes, while he could not get her to accept that the symptoms were a consequence of her poorly managed diabetes (cf. Kleinman 1997):

The doctor asked if F [patient] had any problems, and she replied that she was feeling some pains on the back and on her wrist. She also complained of typhoid, gastric pains and malaria. The doctor explained that it was not what she thought… She informed the doctor that her diabetes was treated and getting finished, so she concluded that her problem was now typhoid and not diabetes. The doctor enquired about her drugs, “You were supposed to take Glibenclamide, one tablet each, three
times a day, and Metformin once”. She looked disturbed and did not utter a word. She tried to argue, and the doctor read out the prescription again. Suddenly he concluded, “I think I will have to put you again on Insulin; you are not well controlled”. She sat motionless not understanding what the doctor meant. She repeated her complaints to see if the doctor would change his decision, but the doctor did not. (fieldnotes, Bafut, 14 August 2002)

In such circumstances, as symptoms and episodes of illness became more manifold over time, there would always be relatives and neighbours to urge the possibility of dealing with the problem once and for all. That meant turning to one of the many specialists offering the possibility of a ‘cure’. Much of the rhetoric of the more senior clinic staff suggests an uphill struggle in the face of patients’ moral frailty and educational shortcomings: against ignorance and self-indulgence, but also against ‘superstition’ and the deceptions of indigenous healers, well illustrated in the frustrated remark of a nurse at one of the Biyem-Assi clinics:

There is one woman who was suffering from diabetes and she stopped her drugs for one year. When she came back [here] a week ago, I took her book to my chief. She told me that she went to Bafoussam… She told me that a traditional doctor at Bafoussam said he will help her not to take drugs all her life, and she helped her and she was fine… As I told you, you have to counsel the patients much. It is difficult with diabetes because I don't know where they control when they visit traditional doctors. (15 March 2002)

But frustrations like this could also be reciprocated by those who took a jaundiced view of both the effectiveness and cost of clinic care. In the words of one Yaounde man, ‘doctors treat us like guinea pigs for pharmaceutical companies, whereas we can get better with traditional doctors” (12 October 2001).

Even where an individual with diabetes acknowledged that the condition required exclusively biomedical treatment, kin or neighbours might well reach their own conclusions about possible causes (and thus appropriate action in response). A case in point concerned the death during fieldwork of a prominent man who had been a strong and very public advocate of biomedicine as the way to manage his diabetes. When he had what proved to be a terminal stroke, there was gossip about whether this had been caused as a result of a quarrel. The possibility that the stroke might be a complication of his diabetes was scarcely mentioned. His death a few days later accentuated speculation as to the ‘true’ cause, all the more so occurring at the start of the dry season, a time of the year widely associated with misfortunes of disease and death and a heightened danger of witchcraft. Such gossip made one man reluctant to give a eulogy at the funeral, fearing that by doing so he might lead others to imagine he had been seeking the deceased’s position. Nor did the problems end there. While the family sought to organize an appropriately lavish funeral feast, they also wanted to make sure that mourners with diabetes had their dietary preferences properly respected. But what exactly were these preferences? Conflicting advice from individuals with diabetes or their families confused the picture. The result was a series of social gaffes in offering food and drink. Initially, for instance, soft drinks and red wine were offered. The soft drinks were rejected, but then switched for beer, which in turn was rejected by some though not by others. Drink was at least offered. Indecision about appropriate food to place in front of diabetic mourners meant that in the end a number of them left early, still unfed and clearly upset. When another member of the family was diagnosed as having diabetes a short while later, there were some who surmised that this might be attributable to failures of hospitality at the funeral feast.
SEEKING DIFFERENT ANSWERS: INDIGENOUS HEALING

As with the opening vignette, this last case illuminates a number of tensions and difficulties surrounding the understanding and management of diabetes, and also draws us towards a closer consideration of indigenous healing. A word first about terminology. We use the general terms ‘indigenous healer’ and ‘traditional healer’ interchangeably. Anthropologists sometimes demur at the connotations of the pre-modern implied by the term ‘traditional’. Yet ‘indigenous’ is arguably too essentialised a term, as also is the ‘ethnomedical’ preferred by some writers (e.g. De-Graft Aikins 2005). Whatever our misgivings, the term ‘traditional healer’ is widely recognized in Cameroon, and its French equivalent, guerisseeur traditionnelle, is equally part of common currency in francophone circles. Moreover, the term tradi-practicien is also common, often seen in advertising of services on sign-boards. Perhaps most typical in local English idiom and in Pidgin as a generic term is ‘native doctor’. The multiplicity of local terms current within a multilingual city means that the more general English or French terms are widespread. These terms embrace a host of diverse specialists, from herbalists to occult practitioners, whose claims to healing skill may rest on the use of plants, animal or inorganic products like earth and stone particles, or divinatory power. Most, but by no means all, are men. While several writers have pointed out that the notion of ‘traditional healer’ in sub-Saharan Africa masks some wide variations of technique and therapeutic practice (Geschiere 1997; Gufler 2003; Pool 1994), some form of divination is common to many of the varieties of indigenous healing practice. Even a common distinction between herbalist and diviner obscures the fact that herbal treatments often accompany divination.

That said, in Biyem-Assi, most of those contacted in this research identified themselves as herbal specialists. Those who would say, for example, ‘I am a doctor of natural medicine, so I use only herbs in healing my patients’, were not only asserting specialist knowledge of plants; they were also often distancing themselves from any assumption that they were practitioners who relied on occult powers. Distinguishing one’s diagnostic practice as based on herbalism could be all the more critical because diviners from certain ethnic groups in the city were widely assumed to be witches themselves (cf. Geschiere 1997, Rowlands and Warnier 1988). As one practitioner affirmed, ‘to understand some of these things about diabetes, you also need to be a witch’. By emphasizing a herbalist identity a healer marked himself off from any such possible association or suspicion, and simultaneously asserted a claim as a serious medical practitioner, with a conscious appeal to a more educated clientele. Signboards advertising an indigenous healer played a part here in claims to status as well as claims to healing skills. Some signs carried graphic pictures, which the advertiser presumably judged would make an impact. Yet healers who belonged to one of several healers’ associations generally looked down on such self-promotion. The very fact of belonging to an indigenous healers’ association was enough of an indication, as they saw it, of trustworthiness, and a sober signboard or even the absence of advertising was a mark of respectability. It was practitioners such as this who were the more likely to want to reassure their patients that they offered the specialist knowledge to enhance rather than entirely supplant the efforts of biomedicine, implying – and even advocating – a partnership of sorts (though few were under any illusions about the response they usually received from ‘hospital doctors’), as the following remark indicates:

If a patient is above [beyond] the hospital doctors, they should send him to traditional doctors... The way you receive a patient also matters. We don’t refuse patients because of money. Medical doctors always ask for tests so as to be able to treat. Others just go into giving treatment without testing. Medicines work according to blood. We
need to work hand in hand because the medical doctor can even contact us when the patient is in hospital. It will be good for us to co-operate. But medical doctors say they can’t co-operate because they say the government has not recognised traditional doctors. Some of them even come to us, take drugs privately and use them in treating their patients. We do not also co-operate because they exploit us to learn our leaves. When we go to meetings, they don’t pay us. They discriminate against us. The government does not encourage us to work [together]. (indigenous healer, Biyem-Assi, 16 October 2001)

Yet whatever the techniques of diagnosis taken by such a healer, a damaged social relationship was invariably identified as the ultimate cause of diabetes, exemplified through the harmful intervention of either an ancestor or a witch (as an enormous literature on divination testifies). Without rituals to restore ancestral protection (a matter to be affirmed in public), or nullify the threat from witchcraft (a matter to pursue in private, indeed in secret), there could be no final restoration to health, no ‘cure’. In this respect, diabetes is seen as like many other diseases, however ‘new’ it may be: one of numerous possible vehicles for manifesting damaged relationships, and just as amenable to restorative treatment as any other. It is in this explanatory framework that the claims and demands of the diabetes clinic get set alongside alternative claims relating to the capabilities of affronted ancestors or witches, as the next comment by a traditional healer suggests:

Shugar can be around and when a problem occurs in a family, the diabetes will find its way in. It can also happen when a family installs a wrong successor. The ancestors immediately make people in the family to be sick with Shugar. But, if the family decides to install the right successor afterwards, the diabetes will finish.… I will tell them to go and do Country Fashion [see note 1] and return to me for treatment. If that is not done, the Shugar will continue to be there, no matter what you do. (Bafut, 3 March 2003)

The dismayed protestations of more senior clinic staff that biomedicine could not possibly be considered on a par with rites to placate ancestors or counter witchcraft was daily confronted by the evidence that many Cameroonians of all social strata (including on occasions biomedical practitioners themselves) did indeed feel justified in weighing up the pros and cons of biomedicine and traditional healing in treating diabetes, and would readily combine the perceived benefits of both. Clinic and traditional diagnoses and forms of treatment thus contended for credibility, as the following comment by a man with diabetes in Biyem-Assi shows:

I cannot believe what the people in the hospital told me. It was just exactly what the native doctor told me. They told me that the level of the sugar was very high. At the hospital those nurses tried to tell me that it might be because I had a lot of weight and that I should reduce it. I have already lost weight and they still want me to do so. Some people were already thinking that I have AIDS. This is not how I used to be. I will just finish these their drugs because I bought them. But tomorrow, I will go for more protection and tell the native doctor that he is a man. He knows his job. I must not joke at my workplace because there is a lot of witchcraft and jealousy there; they have put this diabetes into my body. My family told me in the village that I should be careful… My man will cure me and that enemy will be ashamed. (23 September 2001)

In short, while diabetes is considered a ‘modern’ disease, when it is recognised at all, it is not typically considered something that ‘modern’ medicine alone can treat effectively. In the
final section we examine in more detail both causal explanations for diabetes and the meanings attached to notions of the modern.

EXPLANATION, MODERNITY AND CREDIBILITY

The three previous sections have emphasised that while clinics treating diabetes emphasise to their patients that biomedical treatment is totally incompatible with recourse to indigenous healers, their staff are habitually confronted by clues that their patients feel few inhibitions in moving pragmatically between such incompatible therapeutic approaches. Privately and often surreptitiously, clinic staff themselves may follow suit. All this, moreover, was just as evident in urban Biyem-Assi as in Bafut. What are the local explanations for such a patent disjunction between clinical expectations and therapeutic realities? Two main explanations were offered by clinic staff. The first was moral and psychological, and dwelt on the resolve (or rather the lack of it) of patients. Christian connotations of sinners straying from the path of the righteous were never far away in such depictions – not surprisingly bearing in mind that three of the four clinics in this study were Christian and evangelical. Predictably, this was not a frame of reference much favoured by those who themselves suffered from diabetes. Interestingly, however, it was shared by the wives of some diabetic men, frustrated with what they saw as their husband’s unwillingness or waywardness in following clinic advice. A second local explanation was economic in character, and emphasised poverty and material hardship. The costliness of clinic treatment – specifically pharmaceutical drugs – was indeed something that patients and their families commonly bemoaned, and as we mentioned allocating funds to such medical costs also had a gendered dimension. To some degree clinics recognised this, and Awah was reminded that particularly in Yaounde the poorest were unlikely to be registered with a clinic at all, the implication being that those individual patients included in this study almost by definition did not come from among the poorest.14

What this local reasoning does not touch on is the way in which contention around compliance draws on tacit notions of what is or is not modern (cf. Ferzacca 2001). This is to link the ethnography we present here with a larger literature in the anthropology of sub-Saharan Africa, focussing in particular on the ‘modernity’ of witchcraft today. Before discussing how our ethnography relates to this literature, it is worth clarifying what we mean by suggesting that these arguments concerning patients’ compliance with clinic strictures draw upon tacit notions about modernity and what it means to be modern. Although we use the word ‘tacit’ here, the idea of the modern is not some intangible abstraction (see Nyamnjoh et al 2002; Page 2007; Rowlands 1995). On the contrary, clinic rhetoric – particularly in Biyem-Assi – repeatedly asserts an image of what ‘being modern’ entails. This is promoted by senior staff quite consciously, with both educative and moral intent. Moreover, the bureaucratic procedures and time discipline expected of patients, the routinized laboratory tests and measurements, the unfamiliar understanding of the body and its ailments, as well as a new terminology, all combine to express the distinctive character of ‘modern medicine’ in relation to the management of diabetes. Clinic rhetoric thus fosters a set of associations between scientific knowledge or procedures and the rejection of ‘tradition’ or ‘superstition’ as the foundation of modern thinking and the cornerstone of better health (see note 9). That message is reinforced moreover as the state becomes increasingly active in promoting public health responses to chronic diseases, such as diabetes, seen largely as diseases of modernity, and caused primarily by changes in diet and ‘lifestyle’. Thus, a further association is made in clinic rhetoric between a modern disease that is only knowable and treatable by modern medicine.
Such forceful rhetoric in the context of diabetes management seems to consign indigenous healing and all that it entails firmly to the category of the pre-modern or unmodern. Yet interestingly a number of anthropologists have argued over the last two decades that witchcraft (or sorcery) is anything but unmodern, in writing that is highly germane to our own focus on diabetes and indigenous healing. Cameroon indeed has figured prominently in theoretical debate about witchcraft or sorcery in recent anthropology, notably with Geschiere (1997) and Rowlands and Warnier (1988) arguing that the politics of the postcolonial state has fanned rather than dampened the conditions for witchcraft to flourish, to the extent that it can be seen as “a popular mode of political action” (Rowlands and Warnier 1988: 129). More generally, Geschiere’s *The modernity of witchcraft* (1997) argues a now well-supported view that the ubiquitous presence of witchcraft in public and private affirms its salience for discourses around modernity in many parts of sub-Saharan Africa (cf. Ashforth 1996; Comaroff and Comaroff 1993, 2003; Moore and Sanders 2001). Far from being anachronistic and left behind by modernity, as the older rhetoric of progress and development would assume, witchcraft shows no signs of fading away as an explanatory idiom through which to make sense of changing circumstances. This is just as true of the urban scene as the rural (Nyamnjoh 2001; Rowlands and Warnier 1988). Witchcraft, and the constellation of practices produced by such beliefs, is thus more than simply compatible with modernity; it may be revitalized by it. A revealing commentary on the prominence of witchcraft in Cameroon today is also provided by what Geschiere calls “a dramatic shift in jurisprudence” (1997: 169). Where the colonial state (and for a while its successor) had sought to suppress witchcraft accusations, nowadays those suspected of witchcraft are much more likely to be charged and face heavy sentences. In this process, indigenous healers may have a newly recognised and highly significant role to play as prosecution witnesses.

Yet in what sense does this evident ubiquity imply modernity? In what way is the capacity of witchcraft – and by extension all indigenous healing practices – for revitalisation an expression of modernity? Not all recent anthropological writing on witchcraft in Africa has in fact been persuaded by the claims made for its modernity (Rutherford 1999; Green 2005; Sanders 2003). Green and Mesaki, for instance, stress its “explicitly unmodern associations” in southern Tanzania (2005: 371). While contemporary cultural and political dynamics may well foster the prominent place of witchcraft beliefs in Cameroon (and other countries of the region), and as Geschiere suggests even give rise to new forms of witchcraft (1997: 166), does it follow that such a constellation of ideas about health, harm and cure are construed by Cameroonians as ‘modern’, an integral feature of modernity?

No unambiguous answer seems to us wholly credible, and we rehearse in these two final paragraphs the contrasting perspectives necessary, we judge, to a nuanced conclusion. The range of writing arguing for the ideological prominence of witchcraft in African public discourse is certainly persuasive. Yet using diabetes as a case study we take the view that the ‘modernity of witchcraft’ line of reasoning also underestimates the force of science and biomedicine in people’s lives. By showing how people move between alternative systems of diagnosis and treatment it is true that we have emphasized the continuing fragility of biomedicine’s impact and the accompanying clinic frustrations. But equally we would stress that what clinics offer is not easily discounted. Moreover, the rhetoric which accompanies clinic practice promotes, as we have seen, an insistently emphasised dichotomy in which ‘modern medicine’ stands opposed to ‘traditional superstition’. Such language carries weight, and is buttressed in the case of many clinics by the additional authority of various Christian churches. It may frustrate the more senior clinic staff that patient compliance with their regime proves so hard to secure; but even so, patients first get their diabetes diagnosed in
clinics, start their treatment there, and do return, albeit inconsistently (cf. de-Graft Aikins 2005). Moreover, those who survive over the long term with their diabetes (for many of course do not, as complications increase) tend to become confirmed advocates of the benefits of clinical medicine, increasing the currency of such ideas and influencing the local climate of opinion. What Geschiere and others may thus have overlooked is precisely this indigenous counter-argument to the association of witchcraft (and by extension traditional medicine) with modernity, deriving its authority through clinic practice but ultimately from the status of science as one of the universal benchmarks of modernity. And within this frame of reference, we contend (contrary to Ferzacca (2001)), while indigenous healing may be ubiquitous it can never quite escape from its positioning by default as biomedicine’s unmodern ‘other’.

None of this, however, is intended to minimise the arguments on the other side. To start with, the evidence presented above points towards a number of traditional healers consciously resisting that ‘unmodern’ label, and repositioning themselves as potential partners with biomedicine, appropriating elements of the language as they do so. Clinics may (and do) deride such pretensions. Yet the World Health Organization’s endorsement of the declaration by the African Union of 2001-10 as the ‘Decade of Traditional Medicine’ also undercuts such an unbending clinical stance. In any case, the attraction and the power in popular consciousness of the explanations and ritual solutions proffered by indigenous healers cannot be gainsaid, whatever view is taken of their efficacy. Despite the strictures of clinic staff, people carry on oscillating between – and blurring the boundaries between – the two frameworks of knowledge and practice, and they do so because the promise of the indigenous healer remains inherently plausible to the majority. Moreover, hard as it was for more senior clinic staff to recognise, the science on which biomedical knowledge and procedures rest was far from being taken as the axiomatic bedrock of reliable knowledge that its practitioners and advocates assumed to be self-evident. The clinic regime could thus become, for a good number, both costly and unconvincing. It was not the intentions of clinic staff that were doubted. Rather, it was the explanation for diabetes, and the prognosis, which met with scepticism. The result was that, in the weighing up of diagnostic and therapeutic alternatives, biomedicine could easily be seen as less plausible than ‘traditional’ knowledge. What was seen by clinics as a flight from reason was seen instead by those living with their diabetes as a sensible (one might say modern) testing of the claims and capabilities of alternative medical approaches. For those suffering from diabetes and their kin the unpredictable interventions of ancestors or witches were commonly taken as perfectly plausible eventualities in themselves, in Biyem-Assi and in Bafut. Thus, when such diagnoses were offered by traditional practitioners, the possibility was not an outlandish one for those consulting, notwithstanding the disbelief and dismay of clinic commentaries on hearing such stories. Instead, recourse to these traditions came with all the trust accorded to something that was taken as ‘second nature’.

NOTES

1. Paschal Awah had gone to visit this patient that evening, and had been asked by a nurse to wait as the family was ‘doing some country fashion on her’. Later, he was invited in, and one member of the family remarked: “These doctors here do their best and since they cannot do everything, we bring the native doctors to drive the witches that put the sick, so that the doctors can succeed” (fieldnotes, Bafut, 14 January 2003). This was not an isolated occurrence. Country fashion may be glossed as ‘traditional/customary ritual’.
2. Fieldwork was conducted by Paschal Awah for his PhD (June 2001-June 2003), with Peter Phillimore as his anthropological supervisor (Awah 2006). As it is unusual in anthropology for supervisors to co-author their PhD students’ subsequent papers, we note that in this instance Peter Phillimore assisted Paschal Awah to relate his fieldwork data to broader debates about medical knowledge, witchcraft and modernity, and shared in the writing of the paper.

3. The four clinics were the Etoug-Ebe Baptist Health Centre, and the EPC Djoungolo Hospital Annex, both in Biyem-Assi; and the District Hospital, and Nsem Presbyterian Health Centre, both in Bafut. All but the Bafut District Hospital were funded and run by Christian Health Boards. The largest, Etoug-Ebe, had 120 diabetic patients registered; they were expected to attend strictly organized monthly sessions. The Djoungolo clinic saw about fifteen diabetics and held weekly sessions. The District Hospital in Bafut saw more patients (c. twenty-five) than the small Nsem Health Centre; it also ran diabetes clinics twice weekly, against monthly clinics at Nsem. During fieldwork, further diabetes clinics were set up in both areas.

4. Numerous languages are spoken in Yaounde, and those individuals included in the Biyem-Assi part of this study came from several different ethnic and language groups. However, French was the language generally used in the Biyem-Assi fieldwork, other than among those from Anglophone Cameroon where English or Pidgin was more typical. Most quoted remarks from Biyem-Assi have been translated from the original French.

5. In the words of a Bafut resident: ‘Most of those with diabetes are rich people. They live modern lifestyle. They enjoy life so diabetes also enjoys living in them.’ (2 December 2002). The spouse of a Yaounde patient echoed this view: ‘This disease mainly affects rich people, not the poor. If you are not a modern person, living in those rich neighborhoods, then you are less likely to get it’ (7 September 2001).

6. One man with diabetes in Biyem-Assi remarked: ‘I could urinate about eight times a night. I did not know until I tasted a sample of my urine and it was as sweet as sugar.’ (patient, Biyem Assi, 4 April 2002)

7. It is worth noting that in Bafut clinic staff would generally know and acknowledge the status of their patients and where appropriate their traditional titles. Older men would be addressed as Taa and women as Nde, and a degree of respect or deference was commonly shown by nurses. This made it easier for some to pull rank to circumvent clinic timings, as one nurse lamented: ‘these big people think that the doctor’s consultation is different from what I do. Does he not use the same machine?’ (18 September 2002) In the Biyem-Assi clinics, by contrast, patients were called by their names without any deference to titles (to the annoyance of several patients), ostensibly to reflect principles of equality of access. However, the greater formality and distance preserved between staff and patients also reversed the power differential often apparent in Bafut, leaving patients in Biyem-Assi with very few exceptions deferring to staff. This no doubt assisted the markedly didactic style of patient instruction observed in the Etoug-Ebe Health Centre.

8. We use the word ‘compliance’ deliberately, rather than the term ‘adherence’. In this we follow the literature stressing the connotations of control and discipline implied by the former term, especially by those writing from a Foucauldian perspective. But more
importantly, we use ‘compliance’ because that was the word used habitually by clinic staff during fieldwork.

9. This was well reflected in another instructional session in the Etoug-Ebe Health Centre: ‘If I have asked J [patient] to talk [to you], it’s because he is an old patient and he understands that tradition has nothing to do with diabetes… You meet your friends and they tell you wrong things, that diabetes cannot be treated by modern medicine. So you go and take traditional medicine. When you come here you start telling us that you think that it is this or that thing, whereas we know what is wrong with you.’ (21 February 2002)

10. The growth of understanding about transmission in the case of HIV/AIDS had led some to think that diabetes might be sexually transmitted. The spouse of one man with diabetes complained: ‘my husband told me that I am responsible for his diabetes; that I gave him through sex. I don’t know if diabetes is also sexually transmitted.’ (Bafut, 7 November 2002)

11. One woman in Biyem-Assi (who did accept the chronic nature of her diabetes) remarked: ‘When I was returning from Church last Sunday, a young girl having a walk with her mother commented in my hearing, “Mama, see, that woman has lost weight. Has she got AIDS?” I felt like hell. I was ashamed and thought I was going to face that challenge for life.’ (14 January 2002)

12. In that sense, however much a practitioner stresses the respectability of purely herbalist credentials, there is still an expectation that he will be able to ascertain, through one form of insight or another, the harmful intervention of an ancestor or witch.

13. This comment is a reminder that self-discipline is not only required in complying with a biomedical regime of diabetes treatment, but that indigenous practitioners also make strict stipulations which may require a degree of self-discipline. Nonetheless, in one crucial respect this ethnography suggests a major difference. From a clinic perspective the biggest of all lapses in self-discipline is for the diabetic to ‘stray’ to traditional medicine. There was no indication of an equivalent interdiction by practitioners of traditional medicine. Indeed, as is illustrated in the vignette which opens this paper, it was the willingness to supplement and make good the supposed deficiencies of biomedicine which was characteristic – and also in itself a major problem for the clinics.

14. Contrasting with this, however, is the impression some informants had that diabetes generally afflicts the rich rather than the poor (see note 5).


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