Chapter Two

HEALTH AND ILLNESS IN OVAMBOLAND

This chapter seeks to establish the state of health and illness in Ovamboland, together with some of the beliefs and practices pertaining to each. The health perspective is included here (following Janzen, 1981), in order to contextualise the discussion of illness and affliction, as well as to present a positive as well as negative perception of Ovambo therapeutics. To merely focus upon affliction is to offer a rather skewed interpretation of any given medical culture. Nevertheless, it ultimately receives more attention, since it is with illness and other forms of affliction that much of Ovambo therapy is after all concerned.

I present both Ovambo classifications of symptoms and recognised conditions, and the biomedical definitions of diseases known to be prevalent in the southern Angola/northern Namibia region, although it must be stressed that these discussions are essentially separate. The intention is not to make rigid comparisons between Ovambo and biomedical definitions of ill-health, nor will I attempt to consciously mould Ovambo symptomatologies into biological classifications, or evaluate them judgementally. The aim is simply to provide as much information relating to the incidence and prevalence of ill-health, and the forms it takes, as possible: the idea being that Ovambo and biomedical definitions together allow for a fuller representation of the medical situation. Where comparisons have been made, they are based on those offered mainly by qualified medical doctors (both government and missionary), and are best regarded as possible rather than probable corresponding definitions.

The advantages of portraying both perspectives have been highlighted by a number of medical anthropologists, including Loudon (1976), Lewis (1976) and Bibeau (1982). Loudon (1976:39) pinpoints other areas of social anthropology where external categories, which are more or less universal categories, are available and which, if used with reasonable caution, make possible comparative analysis over time and space. He cites ethnobotany and ethnozoology as two obvious examples, arguing that if social

anthropologists are willing to accept these, then why not biological disease classifications?

I agree in the main with Loudon's train of thought, however there are a couple of problematic aspects. Mainly, these revolve around the fact that it is in a sense easier to align and compare scientific and 'folk' classifications of plants and animals, since both genre are essentially fixed and tangible phenomena outside of the human domain. Illness and disease, on the other hand, form a much more complex category. Except for those somatic symptoms that present themselves, either on the skin or in the form of bodily substances (e.g. vomit, blood, excreta), much affliction is invisible: it is more acutely experienced than it is observed, directly affecting both body and mind. The same cannot be said with regard to plants and animals. And this is why Ovambo and biomedical definitions are here discussed separately.

Finally a note regarding the terms 'illness' and 'disease'. Some medical anthropologists (Loudon 1976, Yoder 1982, Fabrega 1982) have found it helpful to highlight the distinction between 'illness' and 'disease' made by biomedicine, when analysing a society's medical culture. Within the biomedical paradigm, *disease* refers to bodily dysfunction and/or to the underlying cause of this dysfunction (a cause normally seen as physical). *Illness* refers to the individual's experience of disease. Thus in the biomedical system physicians diagnose and treat diseases, while their patients suffer illness (Eisenberg, 1977, in Yoder 1982:10).

I find the 'disease'/'illness' distinction very problematic, because it tends to carry loaded (biomedical) assumptions which are largely inappropriate to the study of other medical cultures. For example, if 'illness' refers to the individual's experience of 'disease' (as biomedically defined), then it implies that the disease has to be *really there*, otherwise 'illness' is illegitimate and gets reduced to neurosis/hypochondria - a totally unsatisfactory situation. Much more useful is the general term 'affliction', regarded by Jervis (1990)[1] as being important because of the crucial case of 'mental illness' which, he argues, can genuinely be viewed as suffering *whether or not* there is an underlying disease that causes it ('disease' in biomedical terms). In other words, if one wants a universal disease/illness distinction, it must permit disease and illness to vary independently of each other.

[1] Personal communication with author.

In relation to the Ovambo, the term ‘disease’ will only be employed when discussing information from medical surveys of the region compiled by biomedics, or by those working within a biomedical framework (e.g. the missionaries). ‘Illness’ is here used independently of the term ‘disease’ (therefore does not automatically imply experience of a physical ‘disease’), and is employed mainly with reference to Ovambo definitions of symptoms and conditions, because the Ovambo conceive of ill-health in terms of an imbalance of body, soul and spirit, rather than as simply physiological disorder. ‘Affliction’ is used when referring to the state of ill-health: a person becomes afflicted by ancestral spirits, or suffers affliction in the form of an illness or some other kind of misfortune. ‘Affliction’ incorporates the terms ‘illness’, ‘sickness’ and ‘disease’, whilst leaving open the relationship between them. That it is a more encompassing term is useful, if one wishes to consider the wider aspects of a society’s medical culture (e.g. the propitiation of the royal ancestors, in order to prevent large-scale affliction in the form of drought and famine).

This chapter begins with an initial focus on health, as opposed to illness, following Janzen (1981:186). Janzen has contested the virtual exclusive focus upon disease taxonomies, causes and therapies, arguing that:

> "This ‘negative’ pathology oriented perspective misses, or under-plays, important though often unlabelled practices or ideas of hygiene, adaptation to the environment, normative health and the conscious maintainance of health ideals" (Janzen 1981:185).

Drawing on a fairly recent study of !Ko health practices (Heinz 1975), Janzen suggests an alternative approach, namely that of looking at African therapeutics from the standpoint of health concepts and practices, from which sickness is a departure and treatment an attempted return. Including the health perspective in an analytical framework allows for a much broader and satisfying analysis, although Janzen does admit that ‘health’ *per se* "...is not readily or so succinctly definable as is ‘disease’". Nonetheless, his approach is arguably both liberating and more realistic in its intention.

Part 1: Some Beliefs and Practises Concerning Health and Hygiene

The Ovambo peoples conceive of a state of health or well-being, *oulinua,* and there are a number of practices relating specifically to health promotion and health maintainance. These practices merit attention as a

separate category since they are not concerned with healing in the strict sense of the word - that is, they are not instrumental in the removal of illness but in its prevention. At the broadest level of enquiry, of course, health maintainance and healing are not completely disassociated, since the ultimate goal of both is the achievement of good health.

Health practices are an obvious indication that a people value their health and are concerned with issues such as personal and environmental hygiene. Notions of health and hygiene are very often culturally-specific, and as such the South African medical officer J. H. Loots (1930:6) was quite incorrect in stating that the Ovambo had no hygienic standards whatsoever. Loots simply measured Ovambo hygienic behaviour against that of his own culture, with the result that a whole variety of beliefs and practices have been ignored and the situation thus misinterpreted.

Ovambo health and hygiene will be discussed in five parts as follows, based on the areas pinpointed by Heinz (1975):

[a] Living conditions: environmental constraints and benefits; organisation of the household (spatial organisation); food storage and preparation; diet.

[b] Personal hygiene: the body; oral hygiene; sanitation.

[c] Pregnancy and birth: normal procedures.

[d] Disposal of the Dead.

[e] Ritual observance: propitiation and prophylaxis.

[a] Living Conditions

Much of the Ovambo region is semi-desert, dependent on the 'annual' rainfall which, if scanty or non-existent, means that drought and famine are common features. Ironically, when the much needed rains do arrive they bring conditions in which malaria thrives. Loots states that the glare from the sun on sand was detrimental to eyesight generally, and added that the abundance of flies during the dry season contributed greatly to the spread of infection (1930:7).

During the 1930's (when the Powell-Cottons conducted their fieldwork) Ovambo settlements consisted of a number of areas surrounded by a main enclosure of wooden stakes. Each household contained a

polygamous family (husband, wives and all children, with some other dependents) and was economically independent. Substantial gardens of millet and sorghum, together with various kinds of fruit and vegetables, lay just outside the household confines. Households are also normally located near fruit trees and, wherever possible, water holes.

Actual living areas are spacious and well organised, with properly demarcated areas for eating, sleeping, socialising, working, food storage and domestic livestock. Areas for animals and humans are (with the exception of domesticated dogs and chickens) separate, the cattle pens being located normally around the outside of the house. Floors inside the house are sandy, although fine white sand is used on some occasions (brought specially from the river areas). The sand is swept often with twig brooms.

Grain is stored in huge baskets, lined with clay and raised slightly from the ground. The amount needed for each day is taken and pounded to flour in the special pounding area. This area is kept free from dirt and small stones etc as much as possible in order to keep the flour clean; it is separated from the rest of the house by a tall enclosure. Large animals are not an everyday aspect of Ovambo diet, smaller wild game and chickens being more usual. However, when cattle are slaughtered, for occasions such as wedding feasts, then the meat is stored on huge, high wooden platforms. Whilst these adequately keep the meat free from sand and dogs etc, they do not really protect it from the sun. The meat fly *(omadi)* **[Diptera** sp] is recognised as a hazard, and raw meat is rubbed with salt to prevent the fly from laying its eggs (Loeb et al 1956:173).

The various utensils used in cooking are cleaned by being rubbed either with sand or with grass bundles. Sometimes dogs may be given bowls to lick clean, however this encourages transmission of intestinal worms. Food is prepared when required, using fresh ingredients (dried meat and 'cabbage patties' and dried frogs being used during the months of famine). Any food which is cooked is rarely kept for longer than one day (A.Powell-Cotton, personal interview, 1988, Quex).

It is considered very offensive to eat using the left hand, since the latter is unclean as far as the Ovambo are concerned. Three fingers of the right hand only are used in eating. Meals are normally communal affairs, with family members sharing two to three large dishes. Beer is passed round in large wooden goblets or mugs, and while such sharing reinforces social bonds it unfortunately aids the transmission of

droplet-infectious diseases like pulmonary tuberculosis.

The diet has been commended by many experts for its nutritional value, with a balance of protein and carbohydrate foods. Any nutritional deficiency in Ovamboland, therefore, is likely to be under-nutrition (not enough of the 'right' food) rather than malnutrition (too much of the 'wrong' food).

Under-nutrition was once thought to be the result of protein deficiency in the diet, however it is now known to be primarily due to "a general food and energy deficiency" (Hunt and Loewenson 1084: 73). Staple foods, argue Hunt and Loewenson (1984:73), may be nutritionally sound, but if bulky then children especially may be unable to eat enough to satisfy their energy (calorie) needs. This problem is of course made much worse during periods of drought and/or war when famine is a real threat. Sanders (1984: 26-27, 29) regards under-nutrition as a crucial factor in determining a people's poor health. Under-nourished children are particularly at risk, since they become very vulnerable to the important infectious diseases - measles, TB, diarrhoea - which can cause death. Also a problem is maternal under-nutrition, which contributes to a difficult labour and to low birth weight babies with imparied chances of survival.

Kwashiorkor is caused by insufficiency of protein in the diet, and tends to be suffered by those people with maize (**Zeamays**) as their staple food. Maize lacks two amino acids - lycine and tryptophane - required for protein development in the human body. If enough meat, beans or milk are consumed, then the deficiency caused by maize is overcome. The Ovambo staples are millet (**Pennisetum typhoides**) and sorghum (**Sorghum cafforum**) which contain all the essential amino acids required, and are therefore a much more nutritious option than maize (Rodin 1985: 84, 86). Rodin (1985:86) states that a few government employees tended to rely on maize exclusively, and that some members of their families subsequently developed kwashiorkor, according to Dr. Gildenhuys, Medical Director of Oshikati hospital. The first two cases of kwashiorkor were identified in Ovamboland in 1973 and may be linked to the fact that corn meal (mealie meal) became readily available in stores throughout Ovamboland.

[b] Personal Hygiene

Personal cleanliness is regarded as important and is maintained on a daily basis. Upon rising, writes Sckär (1916:1), the face and hands are washed with water. This procedure not only cleanses and refreshes, it also

symbolically removes any lingering negative effects of the night as well. As a person washes, for instance, he or she asks the ancestors to bestow fortune and let all misfortune remain in the used washing water (Sckär 1916). The element of transference is strongly apparent here.

In addition to water, the body may be cleaned using exfoliants, especially during the dry season when water is scarce. Sand is rubbed into the skin to remove old *lukula* body grease, accumulated dust and the like (A. Powell-Cotton, personal interview, 1988, Quex). Alternatively a 'body-scrub' *(oyeleki)* may be used, consisting of millet meal mixed with a little water. This is massaged into the skin in the early morning and rinsed off with water using small gourd dippers. According to Loeb, women apparently wash from the head down, whilst men wash from the feet up (Loeb et al 1956:155). Rodin provides slightly more detail about the millet exfolient, saying it is chiefly the coarse siftings of bran, known as *onghundu,* from millet **(Pennisetum typhoides)** that are used. In addition to this the seeds of the *ombudjembudje* plant **(Sesbania microphylla)** are crushed and used to produce a sudsy soap for cleansing the skin (Rodin 1985:38).

The cosmetic oil removed with the above exfoliants itself contributes to personal hygiene. The mixture consists of butter, animal fat or grease from the seeds of the following plants: *omunghete* **(Ricinodendron rautanenii),** *omuongo* **(Schlerocarya caffra),** *enuua* **(Citrullus ecirrhosus),** *domaliua* **(Citrullus lanatus)** and others (Rodin 1985:38). Red powder (either scarlet or crimson) from the pounded heartwood of the *omuuva* tree **(Pterocarpus angolensis)** is added for decorative purposes. This red oily mixture is known as *lukula* and is used on the skin, hair, articles of clothing (especially hide garments), jewellery and other objects (i.e. baskets) (Powell-Cotton catalogue notes: A36/2685b).

Leaves of *embodi lomomadi* **(Ocimum simile)** may be pounded and added to the grease to give it a pleasant 'minty' fragrance (Rodin 1985:38). Indeed, the use of scented body oils is reputed to be an efficient repellent of insects that are potential disease bearing organisms (A. Powell-Cotton, interview, Quex, 1989; Janzen 1981:186; Rodin 1985:38), and insects generally, in addition to protecting the skin from the harsh effects of the sun (Rodin 1985:38).

There are certain plants which are used to make deodorants and perfumes. The herb *injolutope* (mother-of-a-plant-name) **(Sphaeranthus** spp.), is dried, pounded and used as an underarm scented cosmetic by women (Loeb et al 1956:156). Similarly, the dried and pounded young twigs and leaves of *oshive*

(Hemizygia bractosa), or the flowers of *obango* **(Croton gratissimus)** are used as deodorising powders (Rodin 1985:38). The Powell-Cottons state (P-C.A36/2527) that women used such powders after working in their grain fields, as well as when wishing to allure men.

Daily personal hygiene is not directed at the exterior of the body only; there is also emphasis on keeping the interior 'clean' as well. In the main such emphasis is directed at the bowels: the Ovambo prefering to empty them as frequently as possible, and certainly once daily at least. In the event of illness this daily enema requirement is likely to go up if enemas constitute part of the prescribed therapy. Young babies and children were often taken to the mission clinics and hospitals if they had failed to empty their bowels for half a day; enemas were almost always requested [2].

The use of enemas is an extremely popular means of cleansing the body internally, especially since constipation is such a common complaint. The enemas used as part of daily hygiene are therefore almost certainly evacuative rather than retentive, emphasis being on the purgative qualities of the enematic liquids introduced. Ironically, extensive enema-use may lead to, or compound further, problems of constipation. This is because the principle function of the colon is the absorption of water and salt from the faeces before they are expelled. The protracted use of enemas results in over-absorption, leading to impacted faeces and virual non-existant peristalsis due to lack of roughage. A great many plant-based medicines are also introduced to the body using enema appliances.

Sanitation

Loots (1930:6) remarks that much contamination was caused by the amount of human waste which littered the living areas of Ovambo households in Namibia. Yet the Powell-Cottons maintain that great care was taken to keep the living areas free from dirt, including excrement and the like (A. Powell-Cotton, interview, Quex 1989). Within each house is a properly designated area serving as a common urinal: a small place set back from one of the internal passageways. The place was probably frequented most during the night, when it was considered unsafe to venture outside. Normally, however, people would use the surrounding bushland a reasonable distance away (see (Powell-Cotton) Kwanyama household plan). Indeed, *ombato,* the

[2] Dr. Tarek Meguid of Onandjokwe hospital, Namibia, informed me that at present babies are still brought for enemas, and much concern is shown for those who do not empty their bowels often (personal interview 1989).

Oshikwanyama for constipation means literally ‘I cannot go to the bushes’ (Turvey 1977).

Babies and young toddlers are perhaps the exception to the rule, since they do empty their bowels regardless of where they are until they reach an age when they can control them. Mothers are equipped to deal with such occasions accordingly. They carry a small basket *(eiai)* containing a tiny enema reed *(olumbungu/lokhupila okana),* a piece of very soft animal skin *(oipa lokukombe okana)* for cleaning the child, some fine powder made from crushed fungus *(onhgu)* for dusting the skin to prevent chaffing, and a small brush *(olukatero kokukomba)* for sweeping up faeces (Powell-Cotton Angola collection specimens A37/551 & A37/55).

Bowel contents are normally buried in the sand. Indeed, the covering, hiding or disposing of bodily emmissions is taken seriously because of the general fear that people may use them for nefarious purposes. Hiltunen (1986:135), for example, has revealed that sorcerers commonly make use of soil containing traces of urine or faeces of the intended victim.

Perhaps the problems Loots has pointed to stem from the concentration of cattle dung in the neighbouring pens. This dung is used as a fertiliser on the surrounding grain fields and gardens, and whilst benefiting the condition of the soil would attract germ carrying flies. Similarly the excreta of domestic dogs and chickens may prove hazardous.

Menstrual hygiene

Ovambo women practice vaginal douching during menstruation. A douche is known as *komeva* in oshikwanyama, meaning ‘something in water’ (Loeb 1962:259). Loeb et al identify the plant used to make douche liquid as **Solanum panduaeforme,** although other **Solanum** species may be used. In Kwanyama dialect species of **Solanum** are known as *onululu* or *okatululu,* meaning ‘bitter’. The root of *okatululu* is dried, pounded and mixed with water, then used as a douche. Apparently a decoction of the leaves of **Solanum nodiforum** is both diuretic and depurative (i.e. cleansing) and this, claims Pobeguin (in Dalziel 1937:435), would tend to shorten the menses. Unfortunately Loeb does not elaborate further on how douching was performed, or with what.

Menstruation itself is regarded as a depurative rather than polluting process for a woman. In the case

of new widows, for example, the first flow of blood since the husband's death is believed to cleanse the vagina of any semen left by him; thus no purification ritual is considered necessary. Childbirth is considered to be similarly cleansing; a woman who is pregnant when her husband dies, or has given birth so recently that her menses have not yet resumed, does not have to be purified. The arrival of the baby, or the onset of the menses are considered cleansing enough (Loeb 1962:260).

Oral Hygiene

The oral health of the Ovambo peoples is maintained with a combination of suitable diet (e.g. fresh meat and fish, dairy produce, grains, nuts, and fresh fruit and vegetables as opposed to soft, sugary food) and cleaning. A variety of plant parts are used by the Ovakwanyama as dentifrices and mouth washes. The process of cleaning the teeth, using a frayed stick, is known as *lukusha* (Turvey 1977).

Green stems of millet **(Pennisetum typhoides), Sorghum cafforum,** sugar cane, grasses and palm leaves were seen being used as dentifrices by Loeb et al (1956). Small twigs of the *omunhanghuti* tree **(Acacia marlothi)** are used for teeth cleaning, the ends being frayed for use (Loeb et al 1956:154; Rodin 1985:92). The roots of many plants aid oral hygiene, for instance that of the *osimumu* bush **(Royena cuneifolia)** is used as a mouth wash and dentifrice. The Ovakwanyama chew the root of **Diospyros lycoides** (wild persimmon), also known as *oshimumu,* which gives off a red sap and colours the tongue. The chewing is continued until the root is reduced to a bundle of fibres. The teeth are rigorously rubbed with these, and the bundle may be re-used many times. **Indigofera daleoides** and **Tephrosia lupinifolia** both have the same Ovambo name: *okanakafukua* (little-of-peanuts). **Tephrosia lupinifolia** yields an aromatic oil. Both are chewed in teeth cleaning in order to attract the opposite sex. **Albizia anthelmintica, Entandrophragma spicatum** and **Euclea divinorum** are also used in teeth cleaning (Rodin 1985:73).

Loose or bad teeth may be pulled using iron tongs also used by men for plucking their beards (P-C.A36/363). Toothache is often cured by attempting to kill the offending nerve with a heated porcupine quill, or glowing wood coal (Loeb 1955a:38). Alternatively, the latex of *omupindinanguali* **(Euphorbia montieri)** is placed on the infected tooth (Rodin 1985:75).

[c] Pregnancy and birth: Normal Procedures

Midwives attend women in labour, making sure that the new mother, *omuali,* is fed reguarly throughout the day. During her stay in the birthing hut the *omuali* receives constant attention. The midwives make a hole in the ground near the hut which is filled with warm water and herbs. As the pregnant woman lies in the water, the midwives massage her abdomen to make the uterus *(ositungu)* contract (if the process is slow). In the 1950s the umbilical cord was severed with an iron blade *(osimbi)* close to the navel, however Loeb states that formerly the cord was just left to drop off. The afterbirth, once expelled, is taken away and buried quickly, so that sorcerers cannot obtain it (Loeb 1962:225-226).

[d] Disposal of the Dead

Preparations are made for burial immediately following a death, unless it occurs at night, in which case work will begin the following day. The body is stripped naked, save for a single string of beads around the neck, and the skin rubbed with *lukula* grease. Graves are 4-5 feet deep, and the location of them varies depending on the age, sex and class of a person, although all lie within or near to the household area. The Ovambo do not have cemeteries.[3] The body is placed in a crouching, or foetal position, with the head facing towards the East (Loeb 1962:261, Aarni 1982:42).

There are occasions when corpses may not be buried, being instead mutilated or thrown into the bush. The reasons for this kind of treatment are various and relate to beliefs concerning the existence of spirits after death that can influence the lives of living. For example, the corpses of suspected sorcerers and witches would be treated in this manner, as would those of people who had died by drowning, suicide, murder etc. Through mutilation or non-burial, the spirits are less likely to be able to contact the living and cause them harm (Loeb 1962:259-262).

[d] Propitiation and Prophylactic Measures

The Ovambo actively seek to promote and maintain health by adhering to social norms and values, since deviation is believed to result in affliction - sent by offended ancestral spirits, Kalunga or witches and

[3] Except those that are Christianised, of course.

sorcerers. In addition to law abidance and propitiation of living kin and ancestors, prophylactic herbal medicines may be taken. These preventive medicines may be taken alone or in conjunction with the wearing of protective charms, in order to prevent illness, or the recurrence of illness and other misfortune. This aspect of health maintainance is given full attention in Chapter 6.

Part 2: Biomedical Overview

The most common diseases and causes of death in under-developed countries generally are nutritional and communicable diseases (Sanders 1984:26). These two groups interact and aggravate each other. For example, the under-nutrition of people - especially of children - is a crucial factor, as it makes the individual vulnerable to the most important infectious diseases causing death: diarrhoea, measles and tuberculosis to name just a few. Poor nutrition of pregnant women causes problems for both mother and baby (Sanders 1984:26-27). Most diseases occuring in under-developed countries, including Namibia, are listed in Appendix 1, Table 1.1.

Sanders defines *airborne* disease as being spread by breathing airborne, respiratory secretions from an infected person. *Water-borne* diseases are spread when the pathogen is in the water and drunk by people who may then become infected. *Water-washed* illness is spread by the hands, cooking utensils etc. In *water-based* diseases the pathogen spends part of its lifecycle in an aquatic animal (e.g. a snail) (Sanders 1984:27). All the diseases listed in Table 1.1 are found in Namibia with the exception of Guinea worm, smallpox, sleeping sickness, river blindness and louse-borne typhus. The documentary sources indicate that a great many more diseases afflict the population besides.

Disease in Ovamboland

All the diseases present in Ovamboland have been prevalent since the 1920s at least, although varying in intensity throughout this time. Prior to the 1920s the picture is not so clear, except that some of the most destructive diseases (e.g. venereal diseases and tuberculosis) were apparently not widespread. For example, Finnish medical staff writing in the 1920s remark on the fact that fifty years earlier (i.e. around the time of the advent of Europeans), venereal disease and tuberculosis were virtually non-existant. By 1922, however, cases of these diseases, as well as alcoholism, were increasing steadily at Onandjokwe

hospital (Rainio 1922:5-6).

In 1921, 50 percent of the hospital patients at Onandjokwe had syphilis, and one third of those Ovambo passing the entrance exam for the seminary (missionary education designed to produce teachers and preachers) had syphilis. Leprosy was first diagnosed in 1924, and Malta fever, Influenza, Measles and Tuberculosis were all evident by 1927 (Inkeri Taube 1948:42,232-234). The most common diseases observed at Onandjokwe during the 1920s were malaria, dysentery, hookworm, under-nutrition, purpura, tuberculosis and venereal diseases. At this time there was apparently no bubonic plague, apparently no smallpox, no rickets and no sleeping sickness (Rainio 1922:39-40).[4]

In 1930 J.H. Loots, Medical Officer for Ovamboland, conducted a survey of health conditions in the area. He found a high percentage of eye disorders (mainly conjunctivitis and gonorrheal infections), hookworm, malaria, a few cases of typhoid fever, brucellosis (undulant fever), venereal diseases (both sexually transmitted and congenital cases), anthrax, rabies, tuberculosis and leprosy (Loots 1930:7-13). Almost a decade later, the South African Government Report of 1939 classified 5919 cases of illness treated that year in the Anglican Missions of Kwanyamaland (see Appendix 1, Table 1.2) (Loeb 1955a:36).

The English Evangelical Mission of Saint Mary, in Kwanyama territory, Namibia, treated mainly malaria and syphilis, which were regarded as the main causes of general ill- health and scarcity of babies in Ovamboland. Other health problems included burns and inflicted wounds, resulting from fights during beer sessions and cattle raids. Malnutrition, suffered especially during the months of drought and severe food shortage, caused serious health problems and exacerbated other forms of illness (Wolfe 1935:65-67).

During the 1950s, Onandjokwe hospital treated people suffering from measles, bubonic plague and hernias, in addition to those illnesses listed in Table 1.2 (Soini 1953:26, 73, 78). Some years later, during the early 1960s, the Odendaal Report was compiled by the South African government. The following

[4] Loots' thesis of 1930 (pp 23-24) states that monthly batches of lymph, sufficient for 100 doses, were distributed between two missionary centres by the South African Government during this year. He makes no mention of a smallpox epidemic at this time, however the disease has obviously become more prevalent since Rainio's time of writing almost a decase previous. Vaughan (1991:45) states that in Southern Africa, during the period between the Wars, "Smallpox, like plague, reach epidemic proportions through changes in the political economy of this period". Similarly, in Kenya, smallpox epidemics were more frequent during the colonial period and were often preceded by famine or rinderpest outbreaks (Ranger 1992:245). Poverty and lack of funds, says Vaughan, rendered medicine largely ineffective. In Nyasaland there were major epidemics of smallpox in 1919, 1929, 1936, and the late 1940s. In 1929, only 10% of vaccinations given had been successful, and as Nyasaland was a tsetse area it was not possible to cultivate lymph in cows (Vaughan 1991:43-5).

diseases were found to be prevalent, the result of "...personal random sampling of various hospitals in Ovamboland": pneumonia, gastroenteritis, dysentery, tuberculosis, malaria, typhoid fever, liver diseases, intestinal worms, *onyalai (?),* heart and hypertension, nephritis, parametritis, sterility, purpural conditions, meningococcal meningitis, bubonic plague and leprosy. Tuberculin infections show an increasing and alarming trend (Odendaal Report, 1962-3:133, 135, paragraphs 524 & 529).

Recent health surveys (mid 1980s) show that despite the South African government's promises of health care and reforms, gastro-enteritis remains the most common illness among children, and tuberculosis the most common among adults. There is also a high rate of cancer, heart conditions and hypertension, as well as a prevalence of measles, osteo-arthritis, bronchitis, pneumonia, whooping cough and impetigo. Venereal disease is still extremely common, as is malaria. Bubonic plague is still endemic, but became epidemic during 1983 and 1984. Other diseases include hepatitis, diptheria, parasitic diseases and rabies (Brian Hackland 1984:11; Susana Smith 1986:54-55). The mental health of indigenous peoples has deteriorated considerably under colonial rule, damaged especially by the harsh effects of war, refugee camp existence, urban poverty, and detrimental work conditions (Suopettomaki 1973:10; Hackland 1984:17; Smith 1986:55-56; Shishana and Celentano 1985).

For example, since the early 1900s the Ovambo were forcibly recruited by Europeans as a source of cheap and exploitable labour. Many men became migrant labourers in the diamond and copper mines south of Ovamboland, whilst others were required at the farms of white South Africans in the fertile areas of southern Namibia. Despite the claims in the Odendaal Commission Report of 1962-3 (p137), the workers at the Consolidated Diamond Mine at Orangemund cannot have been receiving "...excellent housing, food and medical attention", since a great many serious diseases are mentioned in the mine's annual returns - especially the alarming increase of TB and other lung infections. Poor living and working conditions, together with a general state of ill-health, would undoubtedly have repersussions on the mental health of a person.

Indeed, the system of migrant labour in general can be seen to have had adverse effects on the workers, with long-distance travel, separation from family and friends, and exploitation all contributing to chronic stress. Smith (1986:57) has commented on the problems of rural-urban migration in terms of

physical and mental health. The cramped township of Katutura, on the outskirts of Windhoek, lacks proper services (fresh water, sanitation, electricity) and is divided by the South African government into 'tribal' districts so that unity is prevented and competition and distrust encouraged. In such conditions, states Smith, the incidence of alcohol abuse in high.

In more recent years, the wars in Angola and Namibia have had a dreadful impact on the mental health of Ovambo, the full extent of which is probably still to be realised. On the one hand, the physical hardships of ware in terms of bodily injury will have left emotional as well as physical scars. On the other hand, those removed from the fighting zones, either to refugee camps or to exile elsewhere, have been found to suffer considerably from depressive symptoms. Shishana and Celentano (1985:1252, 1256) have shown that Namibian adolescent refugees suffer from chronic stress as a result of being forced into exile, with the most common symptoms being fatigue, hypochondriasis and sadness, as well as feelings of worthlessness, guilt and self-reproach (suicidal thoughts and self-dislike, however, were found to be rare). In SWAPO refugee camps (where the majority of the 100,000 refugees are women) there is much emphasis on counselling, in order to safeguard against the development of mental illness triggered by traumatic experience (Konig 1984:22-23).

The important link between mental illness and traumatic experience has been highlighted in relation to other African countries - by Fanon (1967: 200-236), for example, in his study of the Algerian Revolution. He argues quite plainly that oppression leads to mental collapse, as does war against colonialism. The kind of disturbances shown by Algerians are classified by clinical psychiatry as 'Reactionary Psychoses', whereby prominence is given to the event giving rise to the disorder. Generally speaking the 'event' is oppression and/or war, and the psychoses may manifest themselves as impotence, accusatory, homicidal impulses, psycho-somatic disorders, heart trouble and muscle stiffness - depending on the particular event (torture, rape, murder witnessing, refugee existence etc) that has provoked the reaction.

Torrey (1980) contributes to the long-standing argument that mental illness has generally increased and worsened with 'civilisation', but unfortunately provides no conclusive evidence. Similarly, Mannoni (1956) argues that colonialism engendered a 'dependency complex', but provides only anecdotal evidence. Carothers (1970: 133) believes that "...there do seem to be grounds for thinking that psychiatric incidence

in Africans is related to deculturation". This view of the situation is, however, challenged by Vaughan (1991:112), on the grounds that it is typical of 1930s- 50s colonial psychiatry with its 'guilt complex'. Relative lack of good supporting evidence is again the main problem here. Nonetheless, despite the problem of concrete evidence in the case of some studies, it can be argued (on the basis of reliable studies e.g. Leighton et al 1963) that psychiatric disorders in Africa are as real and as burdensome as they are in the West (Ben-Tovim 1987:14-19).

Certainly, in the case of the Ovambo, the effects of colonialism on the mental health of people began to be noticed relatively early on in the colonial period. Rainio (1922:5), for example, noted a dramatic decline in the health of Ovambo as a result of the rapidly changing lifestyle brought about by colonialism. She cites alcoholism as being one of the main health problems introduced to Ovamboland by Europeans, which suggests that those suffering from the condition may have been under stress. Some fifty years later, Suopeltomaki (1973:10) cites the trauma of migrant labour as the main cause of psychiatric disturbances observed at Onandjokwe Hospital.

Some Common Diseases:Biological Definitions

Malaria

Malaria is endemic in northern Namibia, but can frequently become epidemic (Loeb 1955:36; Hackland 1984:11). It is actually more prevalent in the region of the Okavango River (swamp-land), than in Ovamboland (Odendaal Report 1962-3:135, para. 536). The disease is at its worst at the wettest end of the rainy season - March to May in Ovamboland - according to Tönjes (1910). Because Ovamboland is only 3300 feet above sea level, and is located in the sub-tropics, the anopheles mosquitoe thrives at this time. Loeb writes that the land has no natural drainage system and a rather high water table, thus the rain stays in the ponds (oshanas), which is crucial for agriculture and grazing, but ironically causes malarial problems (Loeb 1955:36; 1962:142). Symptoms of malaria include high fever, fainting, mild epileptic fits and stomach disorders.

Tuberculosis (TB)

The most common organism prevalent in humans is **Mycobacterium tuberculosis** (Wilcocks & Manson-Bahr 1972). Pulmonary TB has been largely introduced to Ovamboland by Europeans. Indeed, during the early days of colonialism the disease was rarely encountered among local people, according to Lebzelter (1934:233, cited in Loeb 1955). However, the scene soon changed rapidly so that by the 1920s the urban-rural transmission of TB was very apparent to the Mission clinics in the area (Rainio 1922:6). According to Packard (1989:298-299), TB steadily spread throughout Southern Afica from the late nineteenth century, due initially to mining and migrant labour, and later to poverty and labour concentration. In South Africa itself, TB continued to spread until 1950-65, then declined. Control measures involved "exclusionary policies" to keep it out of the white areas.

Loots states that the problem stems from the poor, damp working conditions of the mines. The miners contract the illness here, then pass it on to people in the rural north when they go home on leave (Loots 1930:15). The Tuberculin Survey carried out by Fine (1954) in six large towns in Namibia, shows a "...fairly strong to strong exposure to TB contacts" (Od. Report 1962-3:135, para.541). Furthermore, the Chief M.O.'s report on the Government hospitals indicates an increase from 359 cases in 1957 to 804 in 1961 (ibid. 135:para. 550). Data from the latter's report for the Finnish Missions in Ovamboland show similar alarming increases (see Appendix 1, Table 1.3). Because of this sharp increase the Roman Catholic hospital was obliged to build special new TB wards in order to cope with the problem.

The enforced system of migrant labour seems to be the main reason for rapid spread from the more southern areas of Namibia into Ovamboland in the north. The South African government Odendaal Report frequently stresses that all miners receive "excellent housing and working conditions". However, more recent studies have shown that poor living conditions, together with substandard (and usually dangerous) work conditions, have been major contributary factors in the spread of infectious disease (cf. Hackland 1984:7-8). Even Loots, the South African M.O. for Ovamboland who also acted as medical recruitment officer for the mines, admitted that the damp, dusty conditions in the mines caused TB, and that the disease spread when infected miners went home to Ovamboland to convalesce (Loots 1930:12-13).

Bronchitis

This respiratory disease is usually associated with older age groups, together with those people who are exposed to damp, foggy climates, irritant gases and dust. The condition is also exaggerated by smoking. The symptoms are violent coughing-up of phlegm and spittle, with wheezing. It is a chronic disease, lasting many years until eventually the right side of the heart begins to fail. This causes odema of the legs and ankles, and the chest may become barrel shaped with time (Pears 1976:77). Ovamboland has a very dry climate, but the disease could result from mining work and from heavy smoking.

Bubonic Plague

This is initially caused by a bite from a rodent flea, but once people become infected the disease may spread by droplet infection. After 2-10 days incubation a severe fever develops, followed by swelling of the glands in the groin and perhaps elsewhere. Most common is the glandular type of plague proving 80% fatal (Pears 1976:17). A report compiled by Rose Innes (1950) for the South African government, shows plague to be most virulent in the south of Namibia, with a less virulent strain being found in Ovamboland. The plague reservoir in the latter region occurs mainly in gerbils (**Tatera** sp.), which occur in large numbers and are widespread (Odendaal Report 1962-3, para 539:135). The disease is known by the Ovambo as *uuva uombuku,* the disease of mice (Soini 1953:73).

Venereal Diseases: Syphilis and Gonorrhoea

Syphilis is a serious sexually transmitted venereal disease, and babies can be born with congenital symptoms. When sexually transmitted the symptoms begin with a sore (hard chancre) at the point where the spirochaete of syphilis entered (i.e. the lips, genitals etc). After a short time the chancre disappears. This primary stage is followed by the secondary stage: sore throat, headache, body rash and enlargement of glands. If left alone this stage also disappears, to be followed by the tertiary stage in which a chronic infection develops in some part of the body: for example, chronic syphilis of the skin, the bones, the heart, the liver or the nervous system.

In congenital syphilis the disease is transmitted by the mother to the foetus. The child is often born prematurely or still-born, and is tiny and wizened in appearance. Those children that do survive are afflicted

with eye disorders, ‘snuffles’, and a characteristic flattened nose.

Gonorrhoea is usually sexually transmitted, however babies may get an infection of the eyes - opthalmia - from their mother if she is infected. Also gonorrhoea in young children can result from handling infected clothing and such. The disease in adults is evident by a thick discharge from the sexual organs, and often pain during urination (King and Nicol, 1969).

Both venereal diseases were initially introduced to the area by Europeans, and are now widespread. According to Loeb gonorrhoea has been prevalent in Ovamboland since the men began travelling to south Namibia to work for Europeans (1955a:37). Loots (1930:17) claims that 60% of the population in Ovamboland was syphilitic, with gonorrhoea hardly less prevalent. He blames the Portuguese for infecting southern Angolans, who in turn infected the Namibians. The typical cases observed by Loots involved: gonorrhoeal eye infections and syphilis resulting in miscarriages, sterility and disability (mental and physical). No cases of nerve syphilis (where the nervous system becomes poisoned by syphilis) were diagnosed.

The clinic at St. Mary’s Mission, Ovamboland, dealt with many still-births which the staff believed to be caused by venereal disease. There were also some congenital cases (people with squashed noses and cleft palates) and cases of crippling joints (Wolfe 1935:22,33 & 67).

Yaws is a non-venereal spirochete caused disease which. The disease is characterised by raspberry-like growths on the body, including the face. Younger children especially are affected, and the symptoms normally disappear of their own accord after some time (Pears 1976:16). Yaws occurs in Ovamboland, the Ovakwanyama chewing certain plants in order to diagnose it (Loeb et al 1956:154). Tuupainen argues that it is difficult to distinguish from yaws from syphilis in the field, and as a result there may have been mistaken diagnoses (i.e. yaws wrongly diagnosed as syphilis) on the part of some Finnish missionary hospital staff. This, the picture of VD in Ovamboland may well be a rather skewed and exaggerated presentation:[5]

[5] Vaughan (1991:137), writes that the Uganda VD campaign in the 1920s failed, partly because of "...the increasing recognition of the difficulties of diagnosing syphilis, and, in particular, of distinguishing it from yaws, a disease primarily of childhood and poverty. In addition, she points out in a later paper (1992:299) that there is "...a strong element of social construction inherent in the colonial concern with syphilis in Africa". Colonial medics arrived in Uganda with their own preconceptions about syphilis and ideas about the moral nature of African socities. Such preconceptions are bound to have influenced diagnostic procedures, so that it is not difficult to see how the Finnish medical staff in Ovamboland might classify yaws as syphilis, rather than vice versa.

> "Opinions on the prevalence of V.D. in Ovamboland vary greatly and information received is contradictory. The diagnoses in the Finnish Mission hospitals are in most cases made by nurses on the grounds of the descriptions of the patients. As adequate diagnostic facilities are lacking, many non-specific and other genito-urinary diseases may be wrongly classified as venereal disease. Even the VDRL test (Venereal Disease Research Laboratory) is not reliable since it may become positive for malaria, tuberculosis, infection in the breathing system, leprosy and non-venereal spirochete diseases etc. Up until the 1970's Windhoek was the nearest place for doing these tests on Ovambos. These reservations must be kept in mind when veiwing the VD rate in Ovamboland between 1915-1965" (Tuupainen 1970:130-1311).

Nevertheless, despite her justified scepticism of venereal data Tuupainen does offer a few statistics. I agree with her opinion that the figures cannot be taken as truly representative of the situation, though they are indicative:

> *Ondonga:* Onandjokwe hospital: the rate has varied between 0.5-16.3% of all patients attending the hospital. Ondangwe clinic: From Oct. 1965 to Feb. 1966: 193 Syphilis cases and 316 Gonorrhoea cases = 16.6% (509) of the total 3069 patients. The proximity of the SWANLA trading firm has had an effect on these numbers.
>
> *Ukwanyama:* Engela: Here the numbers are smaller: 1.8-13.8%. From 17.12.65 to 15.4.66 blood specimens for the VDRL test were taken from 256 pregnant women attending Engela hospital. 15% were positive, 5% destroyed or lost, and 80% were negative. The western Ovambo groups have lower rates of VD infection than do the two main eastern groups (i.e. Ondonga and Ovakwanyama).

The above statistics are for those attending hospital only. Tuupainen quotes the Government Report of 1927 as stating VD is 80% prevalent among "... all married natives" (1927:15). Also a Finnish medical doctor who spent many years working in Ovamboland claimed that gonorrhoea affected 80% of people (Tuupainen 1970:130-131).

Brucellosis

This is an animal disease that is transmittable to humans. The most common infections are **Melitensis** in

goats and **Abortus** in cattle. Miscarriage is indeed common among cattle, yet goats show few signs of illness. The disease may be shed in the animals' milk for a lengthy period. Humans catch it, thus, from milk, the handling and eating of infected meat, contact with dung and so on. Ovambo men rather than women are especially prone because of their almost constant contact with cattle and their by-products. The disease affects the liver, spleen, bone-marrow and lymph glands. Symptoms are weakness and fatigue, chills and sweating, annorexia, headaches and abdominal pains. Joint pains are also a prominent feature, especially of the hips and long bones. In addition there may be nervousness and mental depression. Brucellosis is a self-limiting disease, whereupon 50% of people tend to recover in about one year. The death rate is low (2%) (Wilcocks & Manson-Bahr 1972:486ff).

Anthrax

The bacillus of anthrax (like tuberculosis) can exist outside the body, and like tetanus then take the form of spores or seed-like bodies. Anthrax is spread by horses and cattle, who get the disease from eating infected grass. In humans the disease shows in relation to where the germ alights:

[a] Skin infection (from hide/hair) causing a "malignant pustule" or large sore.

[b] Inhaling dust from infected hides/wool causes a form of bronchitis with blood stained sputum.

[c] Consumption of infected meat causes internal anthrax.

In all cases the prognosis is serious. Death is extremely common, preceded by high temperatures, the skin symptoms, lung symptoms or food poisoning symptoms (Pears 1976:115).

Bilharzia

There are two types of **Bilharzia:** that of the bladder, **Schistosomum haematobium,** and that of the rectum, **Schistosomum mansoni.** The main symptoms are blood in the urine or in the stools and a raised temperature. There is also diarrhoea. Bilharzia is caused by parasites which affect people bathing in or drinking infected water. Small swimming forms **(cercariae)** pierce and enter the skin, mature in the portal vein below the liver, and eventually the females lay eggs in the pelvis. These eggs penetrate the bladder or the rectum, depending on the type of fluke, and pass out in the faeces or urine. Should these eggs enter water they hatch out into small moving forms which seek a water snail, develop further in its body, then emerge

as **cercariae** ready to find a new human victim (Pears 1976:18).

Ankylostomiasis (Hookworm)

Hookworms enter the body initially through the soles of the feet, get into the bloodstream and lodge finally in the duodenum. The symptoms are anaemia and stomach disorders. Miners and others working on damp ground frequently contract hookworm (Pears 1976:19). Fatigue and digestive problems are common (Rainio 1922:41), and small children suffer perhaps most of all (Loeb 1955a:37). Loots blames poor sanitation of the living areas for the prevalence of worms (1930:8).

Leprosy:

Leprosy seems to be more common in southern Angola than in northern Namibia. Loeb claims to have seen no cases of leprosy in Namibia, but did among the Ovakwanyama of southern Angola. He cites Lebzelter, who claims that in Namibia the disease does in fact exist but is concealed from Europeans (no explanation given) (Loeb 1955a:37). The incidence of leprosy in southern Angola is mentioned by Loots as being high in 1930, together with some 20 plus cases being diagnosed in Ovamboland, Namibia. Elders at this time claimed that the disease was a new one, its arrival being linked to the Europeans (Loots 1930:18).

Epilepsy

Epilepsy is not a disease as such, but a symptomatic disorder of the nervous system. Epilepsy for example may result following a severe head injury, or illness such as meningitis. It can occur at all ages, but is most frequently experienced by young children. Attacks can be minor (instantaneous and brief loss of consciousness and change of position, then an equally instantaneous recovery) or major (the victim falls down rigid and unconscious, then limbs contract rhythmically until they become limp again and consciousness is regained).

Extremely common in young children are febrile convulsions (known often as ‘teething fits’). This condition is not always associated with epilepsy, since the attacks rarely continue into later years and are not regarded as serious (i.e. in relation to major epileptic fits) (Pears 1976:48).

Disorders of the Joints

A good deal of arthritis can be directly caused by diseases like gonorrhoea, tuberculosis, septic joints, syphilis, brucellosis, typhoid fever and dysentery. Rheumatism is the inflammation and/or degeneration of the muscular-skeletal system. Rheumatoid-arthritis is the inflammation of connective tissues throughout the body - a condition which can strike at any age. Osteo-arthritis is normally associated with the normal process of ageing, and affects the large weight-bearing joints of spine, hips and knees. Hard wear and tear in younger days may set it off in later life (Pears 1976:54-55).

Rheumatic Fever

Acute rheumatic fever is not to be confused with other forms of rheumatism. Many tissues of the body - particularly the heart - are attacked, as well as the joints, and the trouble is due to a sensitivity which has developed to certain bacteria **(haemolytic Streptococci)** which have probably caused a sore throat about 3 weeks before the onset of the disease. The acute phase of the illness usually occurs before 15 years of age, whereupon inflammatory damage occurs to the valves, the heart muscle and the pericardum. There may be acute heart failure at this stage if the heart is severely affected. Otherwise, the valves scar during ensuing years: they become thickened and deformed, losing elasticity and stretch. As a result the heart has to work much harder than normal, with the end result usually being some variety of heart failure. Rheumatic fever is the commonest cause of valvular heart disease, although in rarer cases it can be caused by syphilis (Pears 1976:28).

Nephritis (including odema)

Nephritis is a disease of the urinary system. Acute nephritis often occurs as the result of an allergic reaction to the toxins of **Streptococcus** (i.e. a streptococcal infection of the throat). Symptoms begin with a sore throat which is followed by a headache, vomiting, pain in the loins, a slight rise in temperature. Especially typical is dropsy, or odema, beginning in the face and ankles then spreading to the rest of the body. Blood and albumen might also be found in the urine. The prognosis is good if the kidneys are given a rest by reducing the ammount of protein intake, salt and water. The acute phase can become chronic if the disease is not treated.

Another type of nephritis not associated with streptococcal infection is nephrosis. It develops early in adult life, the first visible symptoms being odema of the face and legs (Pears 1976:45).

Ascites

Ascites is a complication of portal hypertension/cirrhosis of the liver, in which large amounts of lymph-like fluid accumulate in the abdominal cavity. The fluid contains a great deal of precious protein and salt which is lost to the body economy. Ascites also sometimes accompanies cancerous deposites in the abdomen (Pears 1976:38).

Impetigo

This is an infectious skin disease, usually occuring on the face. It takes the form of blisters filled with pus on a red base. When the blisters burst their place is taken by yellow crusts. It is highly infectious and spread by fingers, infected cloths and so forth (Pears 1976:53).

Purpura (Bleeding tendency)

Purpura is an haemorrhagic disease - a disease of the blood conserving mechanism which can lead to abdominal bleeding, either beneath the skin causing bruising and small leaks, or leading to greater loss of blood (particularly following a wound). In some kinds of purpura the blood vessels themselves are the cause of the trouble, having become fragile and leaky for a number of reasons. It can occur, for example, in old age (senile purpura), in scurvy or vitamin C deficiency, as an occasional accompaniment to infective diseases, or as an immunological effect on the lining of the blood vessels when the patient becomes sensitised to certain substances (Schonlein Henoch or anaphylactoid purpura). The latter often follows a streptococcal sore throat, just as rheumatic fever and nephritis do; and indeed joint pains and nephritis may accompany purpura (Pears 1976:77:26).

Purpura is commonly found in Ovamboland. The symptoms are reddish-black blisters on the inside of the cheeks and palate, along with bleeding lips and gums. The blisters break out very quickly with the appearance of wounds. Urine and saliva may also contain blood (Soini 1953:33). Rainio noted bleeding from the nose, mouth and skin. The tongue and skin were usually pale and swollen, and the patient was in a

state of extreme exhaustion (Rainio 1922:28).

Pre-Eclampsic Toxaemia (PET)

This is a condition which affects pregnant women. The causes are unknown, but it has been associated with malnutrition. Symptoms include severe swelling of the limbs, headache, high blood-pressure, visual disturbances, and fits in the later stages. High blood-pressure poses risks for the fetus. Also the possibility of premature delivery, because of placental insufficiency, reduces the baby's chances of survival (Stoppard 1991:162).

Nutritional Disorders

Malnutrition occurs when food is available but is not of the right sort; that is too much carbohydrate, or too little protein. An imbalanced diet can lead to either obesity or emaciation. Under-nutrition occurs when not enough food is available for the body's requirements, even if the diet is balanced. Both nutritional disorders are highly significant in determining the health of a population. If diet suffers then the whole body does and illness is much more likely. In children especially inadequate diet is problematic since the effects can leave life-long scars: in the form of stunted growth, and weak bones (Sanders 1984:26-28; Smith 1986:53-54).

Part 3: Ovambo Concepts and Definitions of Illness

Illness Terminology

The Ovambo categories for illness *(vela)* and other forms of misfortune *(oshiponga:* accident, misadventure, distress, danger, calamity; *oixuna:* troubles, ordeals; *omupya:* bad luck, misfortune), appear to be quite closely interrelated. Victor Turner states that the Ndembu of Zambia consider illness or disease to be a species of misfortune (1967:300). Likewise, Evans-Pritchard offers a similar conclusion for the beliefs of the Azande of Sudan (1937). It is certainly the case that for the Ovambo both illness and misfortune appear to be characterised by elements common to both (e.g. they share the same causal agents and often the same or similar remedies). This is illustrated by Shivuta's remark that ancestral spirits and witches may cause "illness *and* unhappiness in people" (1981:2).

Nevertheless, despite such links there is a wide vocabulary pertaining specifically, if not exclusively, to illness. However, one might expect a greater percentage of vocabulary devoted to illness than to non-medical misfortune, since illness is an essentially personal experience - it affects the body and mind directly, whereas other kinds of misfortune do not share this degree of peripheral or symptomatic precision (Lewis 1976:55). In the final analysis, it is impossible to differentiate between illness and misfortune completely, since taken at the broadest level there are perhaps few (if indeed any) societies who would not consider illness to be related in some way to 'bad luck' - particularly when one considers lay medical perspectives.

For the Ovambo, disease and illness signify a departure - mild or drastic - from the state of *oulinaua\kalonawa:* health. That it is perceived in terms of 'departure' is indicated by the Oshikwanyama term *eveluko,* which means 'health regained following sickness'. Similarly the verb *velula* (or *veluka)* means both to recover one's health as well as to restore to health or to heal (Tobias and Turvey 1954). Thus it is possible to assume with some confidence that health equals the norm and illness an abnormal state of affairs.

A rich vocabulary exists for the ways in which illness and disease are conceptualised and experienced.[6] By comparison, vocabulary relating to health is much more limited. With regard to illness, various levels of gravity are distinguished, as well as a number of pathological definitions. The nouns *oudu, vela* and *oshidu* can be translated as illness or disease. *Oudu wa handuka* refers to grave illness, whilst fatal (i.e. incurable) illness is described by the phrase *ouvela va xuninua,* meaning literally 'last illness'. To die of an incurable illness is known as *fia koudo,* and is thus distinguished from other forms of death such as *lifila* (natural death) or *fia kondjola* (death from starvation) and so on. Serious large-scale illness, such as an epidemic (e.g. bubonic plague), is known as *omukifi.* Periodic illness is described by the phrase *oudu ou na apa hau uja,* in oshikwanyama. The noun *olutapo* refers both to an infection and to contagion; the verb

[6] It must be said that this vocabulary is not wholly comprised of 'original' Ovambo concepts. Certain 'new' terms have been adapted from European medical terms (though whether by Europeans wishing to explain, or by Ovambo themselves, is difficult to say). For example: *okiina*: Quinine (from German/Afrikaans), *onashalesha*: hospital (German, Lazarett). Notwithstanding, this expansion of the Ovambo vocabulary has most probably taken place in the European (missionary) clincs and hospitals, which were keen to succeed the 'traditional' healers and thus began to train Ovambo assistants (the Finns embarked on such a programme at least). It is not an easy task to distinguish the new from the original, but it is nevertheless important to recognise that such outside influences in the vocabulary exist.

kakeka means ‘to contaminate’. Certain health problems are recognised as being congenital, being described the verb *dalua na,* meaning literally ‘to be born with’. The name for an individual who is ill is either *omunaudu* (a ‘patient’), or *omudu,* and the particular illness he or she suffers from is normally adjectively attached. Hence someone with leprosy *(etakaia)* is a ‘leprosy patient’ or leper: *omunaudu uetakaia*. A chronic invalid is known as an *omudunu*.

An illness *(oudu)* is distinguished from an injury *(ejahamo/hepeko).* It appears that on the whole, injury is recognised as being more painful than illness, since the general term for agony is *ejahamo linene*. Pain due specifically to an injury is known as *oujahame*. *Elulumo* refers to acute pain, and is used especially when describing the smarting, burning or stinging sensation of wounds. Colic pains, gripes and Labour pains are known as *fetwa,* whilst *-teka olute* describes the feeling of acute nausea (Tobias & Turvey 1954, Turvey 1977).

Ovambo refer to particular areas of the body where illness is seen to be located in different ways. Either the body part (or general area) may be directly referred to: thus *oudu medimo* (stomach illness), or else the illness may itself be given a name - perhaps without bearing any relation whatsoever to the body part it so affects: *onondo* (indigestion), *ombato* (constipation), and so forth. Names of specific illnesses, bear relation to the *effects* of the illness (i.e. not being able to empty the bowels: constipation), or to the *cause* (bird illness: *oudu odila),* or to the cure.

Ovambo Illnesses

Oudu Odila

This illness affects babies and very young children. No mention is ever made of adults being affected. The Powell-Cottons obtained information from Kaweda, a Kwanyama man from the Kalondo mukunda (district) near Onjiva (southern Angola), who stated that *oudu odila* was a quite common illness and much feared by the women. The illness is contracted mainly by young children not yet weaned, and the symptoms are such that: "....the child clenches its hands, digging its nails into its flesh; it twitches violently and has a high fever. It may fall, giving a curious little cry as it does so. Often it remains in a state of coma. If not treated immediately it will probably die" (D. & A. Powell-Cotton 1936/7a:6-7). The situation is the

same among the neighbouring Dombondola: young children are the victims and it is particularly common among child cattle herders in the bush (D. Powell-Cotton 1936c:5).

Oudu odila is believed to be caused by the *onghombe* bird as it flies overhead (D. Powell-Cotton 1936c:5). Indeed, *odila* is the general Kwanyama term for 'bird' *(edila:* large bird; *okadila:* small bird) (Turvey 1977). The *onghombe* is described as a large black bird, with bright red markings (D. Powell-Cotton 1936c:5). A somewhat fuller description is provided by Loeb et al (1956) who identify the *onghombe* as **Bateleur berghaan,** "....a carrion feeding eagle with remarkable wing performance, including terrific speed and the ability to turn somersaults in flight (1956:170). Moreover, the bird "...rocks from side to side as it steers, sometimes with wings held up at quite an acute angle" (McLachlan and Liversidge 1970:102-3). Certainly the flight antics of the *onghombe* bear a striking resemblance to the convulsive symptoms of *oudu odila,* hence, no doubt, the association of these two in Ovambo aetiology - a suggestion that has been forwarded by Orley (1970:145) in the case of other African peoples such as the Bemba and Ganda.

There is, nonetheless, evidence to suggest that the *onghombe* bird is not regarded exclusively as the cause of *oudu odila*. Kaweda, for instance, maintained that the bird could fly over without actually causing harm to children, whilst on other occasions children might become ill when the bird was absent, in which case the wind was blamed. A male *ondudu* interviewed by Diana Powell-Cotton was in fact quite sceptical about the *onghombe* causing *oudu odila,* although the Powell-Cotton manuscript contains no alternative explanation offered by him (D. Powell-Cotton, 1937b:80). It is plausible to suggest, on the basis of the above, that lay and professional causal explanations for illness might be operative, however much more conclusive evidence is needed before any such claim could be regarded as more than tentative.

Loeb et al (1956:163) have stated that *oudu odila* is actually epilepsy, whereas according to the Ndonga-English dictionary (Tirronen 1986) *ondhila* ('bird') can refer to children's malaria (convulsions). Erastus Shamena of Ukwanyama suggested malaria, or piles of grit in the stomach causing fever and fits (1989, personal interview, FELM, Helsinki).

Elsewhere in Africa there are examples of febrile convulsions being attributed to large (and often predatory) birds. John Orley (1970), for example, has described *eyabwe* ('bird illness'): child epilepsy or

fits, among the Ganda of East Africa, who believe the illness to be caused by an eagle. Orley also cites the Bemba of Zambia as holding very similar beliefs. It is also interesting to note that epileptics are often treated with bird claws (Orley 1970:145). Antoinette Powell-Cotton records the existence of a childhood illness said to be caused by a river bird, *onjudi/ondurudi,*[7] whereupon the afflicted child is scratched with the claws of this bird during healing (A. Powell-Cotton, 1936b:5). Unfortunately, no further information is given and this 'river bird illness' is not mentioned in any of the other source materials examined. Somali children wear charms and bells in order to protect them from the *gummess* bird as it passes overhead (D. Powell-Cotton, Somali field notes, 1935).

Certainly, convulsions are common among babies who are teething. In the particular case of the Ovambo, malaria could be the main reason for convulsions in children, especially among those out in the bush such as the Dombondola herdboys mentioned earlier. If simply febrile convulsions, then children will outgrow these in time, unless of course epilepsy proper develops (Dr. Tarek Meguid 1989, pers. communication).

Akwamungu: Spirit Possession

Akwamungu appears to be two things;

[a] *Akwamungu* is an illness said to be caused only by the spirit of a dead relative, who in his/her lifetime was also thus afflicted. The spirit of the dead is said to enter the living (Dombondola, Ovakwanyama and Ombadja peoples) (D. Powell-Cotton 1936c:1).[8]

[b] *Akwamungu* "is an almost mythical personage" - cause of all personal misfortune. Thus if a house falls down, or if earthenware pots crack, or if other bad things befall one single person, then that person is possessed by *akwamungu* (Dombondola mainly hold this view).

So, although *akwamungu* can be seen to be a very specific illness ('a'), it may manifest itself as some other form of misfortune not actually connected with *illness* at all ('b'). This vividly illustrates the

[7] Possibly, onjundu: pelican.

[8] Diana Powell-Cotton states that the spirit *enters* the body of the living during possession. Loeb (1955b:156) describes spirit possession as the voice of the dead coming from within the afflicted. Both descriptions suggest spirit *intrusion* in the event of possession, however I have no further information regarding the precise location of a spirit during possession (i.e. in a vital organ? in the head? on the victim's shoulder?).

artificiality of endless discussions about terminological boundaries in the medical anthropological literature. Usually though, an attack on the victim's body occurs at some point in the affliction process, so it is with the illness aspect of *akwamungu* that I am primarily concerned with in this section[9].

Affliction in the form of illness seems to be of two main kinds: physical and mental. For example, a female potter obtaining clay for the first time during the potting season will be afflicted with blindness, earache and deafness, and "ills of the hands, legs and feet", if she does not burn the necessary plants required by *ovakwamungu* (the ancestral spirits). Moreover, if the potter also happens to be an *ondudu* who has drunk the blood of a cow (i.e. passed the highest stage in a healers initiation), then *akwamungu* will cause her much sickness if she does not also break fresh cow dung (from the bush, not the cattle kraal) on the ritual fire (D. Powell-Cotton 1936e:1-2).

D. Powell-Cotton (1936c:1) records that *akwamungu* normally affects only women among the Ombadja, Dombelantu and Dombondola; however among the Ovakwanyama it may affect men as well. She offers no explanation for this, but if by 'men' she means the *omasenge* 'not-men', then her description makes more sense, since they are more 'female' than 'male'.

The symptoms of spirit possession are a general feeling of sickness and wasting away. Any part of the body can be attacked (e.g. the joints), but in general the person becomes thin and can eat little. There is delirium in the later stages, bordering on madness. The afflicted person often escapes from their household and careers through the bush - not noticing thorns or fences. Finally, the protagonist collapses - as if dead - in someone's household. It is at this point that an *ondudu* will be consulted (D. Powell-Cotton, 1936c:2). This form of spirit possession is the kind normally regarded as a calling to the *ondudu* profession.

Depression and delirium are not the only symptoms of *akwamungu*. In an incident observed by the Powell-Cottons, a woman was experiencing a difficult and protracted labour and so an *ondudu* was summoned by her husband. The *ondudu* divined with a knife over his ash-covered palm and duly announced that it was *akwamungu* - the spirit of Hamunjungo's father who had entered his pregnant daughter-in-law. Directly the child was born, Hamunjungo said: "Tu! (ritual spit), akwamungu", and named his newborn son

[9] Chapter 6 deals with the misfortune aspects of akwamungu.

Kaiyamiso - after his dead father (D. Powell-Cotton, 1937b:83). This case illustrates well the occurrence of spirit affliction when the ancestors feel they have been neglected or wronged in some way. The naming of the baby after his late relative appears to rectify the situation.

From the rather limited evidence, it is clear that there are varying degrees of spirit possession within the two main types ‘a’ and ‘b’, ranging from serious to less serious Lewis (1989:28-9) has described "central" and "peripheral" possession - see here, Chapter 4, sub-section *Spirit Possession and Mediumship* for more information). At one end, for example, there is the serious form of ancestral spirit possession - the kind which is usually interpreted as being a calling to the healing profession. Next we see the severe reprimand or significant warning, followed by the less serious forms (i.e. the illnesses become less serious). Finally, at the other end we can observe the non-illness kinds of spirit-caused affliction (e.g. the cracked pots). The notion of a possessin (i.e. intrusive) spirit is strongest at the severe end of possession, since there is more emphasis on discovery and exorcism of spirits at this level than there is at the level of misfortune.

The Powell-Cottons mention another ancestral spirit-caused illness: *ohula*. Like *akwamungu, ohula* is caused by the spirit of a deceased relative and is expressed by the phrase: *omnhu tavela ohula* (a person is sick of *ohula)*. With regard to symptoms, afflicted persons become thinner and thinner and grind their teeth. They will apparently die if not treated with cattle blood. It is not, however, generally regarded as being as severe an illness as *akwamungu*. This is evidenced to a degree by the fact that a spirit causing *ohula* cannot also cause *akwamungu;* also, the healing ritual with the *omakola* is not necessary for *ohula*. Worth noting nonetheless, is that both these forms of spirit possession need treatment with cattle blood - the only illnesses to do so. (D. & A. Powell-Cotton, 1936/7a:6). Furthermore, *akwamungu* or *ohula* ought not to be confused with *oudu uenangaleto* (literally: ‘wasting sickness’), since this is actually phthisis (Tobias and Turvey 1954).

It is noticeable that spirit possession is totally unaccounted for in the disease surveys conducted by European medical personnel.[10] Even the psychiatric symptoms are not recorded, with the exception of Toini Suopeltomaki’s work. Suopeltomaki talks about psychiatric disturbances observed in Onandjokwe hospital, and gives the main reason for these as the trauma of migrant labour. Other common causes

[10] Loeb states that insanity was not dealt with by hospitals (1955a:39).

suggested are:

[a] having a strange role in the village[11]

[b] psychosomatic patients.

[c] hysteria (1973:10).

Although not referred to directly, *akwamungu* could belong to the descriptions above, although there are many other psychiatric illnesses recognised by the Ovambo.

Other Spirit-soul Illnesses:

These can be roughly divided into two main types: (a) those characterised by depressive symptoms, and (b) those characterised by symptoms of 'insanity' or mental instability.

[a] *Depression:* The Ovambo have a wide variety of terms describing psychiatric states such as melancholia. *Oudwonya* or *eudifonya* are Kwanyama nouns for melancholy, low spirits or depression. *Ndjaalela* is the verb to feel downhearted and depressed, *oshimwenyo* is to be depressed or in low spirits, and *polimana* is to be gloomy and downcast. *Oshisho* is usually used when refering to an incurable wound, however it may also mean anxiety, worry or concern (Turvey 1977).

Depression is normally described as *oudu omutima* (illness of the heart) (Powell-Cotton catalogue notes: A36/2205).[12] The heart *(omutima)* is believed to be the repository of the soul *(omuenjo)* (Loeb 1955a:38; Aarni 1982:66-69; Savola 1916:70-71). Certainly the heart is recognised as being the seat of the emotions: temperament, moods, disposition, humour, morale, stamina and so on (Savola 1916:70-71). Thus *okaana kom omutima* (literally: 'child of the heart') is the conscience, and *oluudo lomutima* is emotion, sentiment or feeling. Feeling sentimental or sorrowful is described in terms of 'one's heart going out', whilst a shock - *lya omutima* - is expressed as a 'bite into the heart' (Turvey 1977).

There is no satisfactory evidence in the available literature to suggest what Ovambo causal theories for depression might be. One obvious factor would be possession by an ancestral spirit. Sorcery and

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[11] The strange role is not specified, but may refer to an ondudu.

[12] The link between the heart and neurotic illness features in other African societies: the Ganda, for example, have two such 'heart' conditions (Orley 1970:146).

witchcraft are other strong possibilities, since both cause misery and misfortune in their victims. Periods of mourning may well be accompanied by spells of depression if the loss is keenly felt. Disputes are usually avoided if at all possible between kin. However, in cases where antagonism or estrangement does occur feelings of angst may set in until the matter is resolved.

[b] *Insanity:* Sanity is known as *omunandunge* and describes "one who has a sensible outlook" (Tobias 1954). There are a number of oshikwanyama terms which refer to the opposite of sanity, or at least deviation from it: *jeveta* (lit. 'to be ricketty': crazy), *osilema* (demented), *dongakana* (deranged), *lialiakana, mendunge* (mentally deranged), *omujananeungu* (lunatic) and *eenghweengu* (madness, rabies and lunacy). There are a few specific illnesses which are characterised by 'insanity'.

[1] Outoni

Outoni is 'ghost call madness' or 'hyena call madness'. If a man kills someone during a cattle raid, then he will be persecuted by the dead man's ghost unless certain precautions are taken (Loeb et al 1956:153)[13].

[2] Emuengu

This illness is characterised by fits of temporary insanity or periodic dementia, usually occuring after too much smoking, alcohol or excitement (Loeb et al 1956:153-4).

[3] Oulai

The main symptoms of *oulai* are shock and stupor. A person may get this following a severe sickness, or after *emuengu,* or after being secretly poisoned (Loeb et al 1956:154). *Oulai* may also be used to describe foolishness, silliness or stupidity in a person (Turvey 1977). Homosexual behaviour in children is referred to as *oulai,* but adults accused of this would regard it as a great insult (Estermann 1976:67).

Insane behaviour may also be symptomatic of *akwamungu* as mentioned above, and in fact insanity and *akwamungu* are synonymous according to some studies (e.g. Loeb 1955a:39).

[13] See Chapter 6 for the ritual purification necessary.

Omulowa (Soul-loss)

This is an illness leading eventually to death, and is caused by an *omulodi* (witch) or someone wielding negative influence (D. & A. Powell-Cotton, 1936/7a:8, Turvey 1977).

Oufimba wa Kalunga

The name means 'pregnancy from Kalunga (God)', and refers to dropsy (oedema of the stomach) caused by malnutrition among other things. Estermann (1976:183) writes that the illness affected both men and women. Loeb adds that the illness was sent by Kalunga as a punishment for transgression and claims that, as such, afflicted persons were ashamed to go to the mission clinics for treatment (Loeb 1955a:38).

Another illness characterised by swelling of the body, is that which affects blood-relations who are not ritually purified after one of their kinswomen has given birth to twins (Loeb et al 1956:152). Loeb unfortunately does not give the Ovambo name for this condition, so that it is difficult to decide whether there is any relationship between this type and *oufimba wa Kalunga,* or indeed *oshifula* - general oedema.

Oluidi

Based on information from Tönjes, Loeb states that *oluidi* is the oshikwanyama for malaria, an illness he says is attributed to witchcraft (Loeb 1955a:36, based on Tönjes 1910). The Kwanyama-English dictionary (Turvey 1977), however, states that *olwiidi* is the general term for fever. The English-Kwanyama dictionary (Tobias and Turvey 1954) gives the Oshikwanyama equivalents of fever as being *oulidi* or *epupialo*. Therefore, it would seem that *ouludi* could be used to refer specifically to malaria in terms of its main symptom: fever, since *oluidi* can be used to describe other fever conditions as well.

Omupanu and *Oshimela*

These illnesses: diarrhoea and dysentery respectively, are in adults believed (among other things) to be due to breaking sex taboos imposed during certain ritual periods. Dysentry in particular is known as 'breaking of the intestines' (Adolf ya Sidine, ELC 1932, item 324:753).

Onteku

Onteku is the Kwanyama name for intestinal worms (?hookworm) (Loeb 1955a:173).

Emhiakani

This is an illness of the knee joints (probably arthritis) said to be caused by transgression of precepts or prohibitions. For example, a man might be struck with *emhiakani* should he fail to observe the feast of *oshipe* ('new things'). Craft workers can also be similarly afflicted should they fail to appease the ancestral spirits prior to commenceing work (D. Powell-Cotton 1936c:1).

Uuva Uombuku

This is literally 'the disease of mice', and refers to bubonic plague according to Soini (1953:73). As mentioned in Part 2, bubonic plague in Ovamboland is spread by gerbils.

Ondjunduzi

This is a boil sickness, apparently caused by witchcraft (Tomas Uukunde, ELC 1932 item 88:217).

Ombulua

This illness appears to be anthrax, which is normally caught from anthrax-infected cattle. the Ovambo certainly recognise it as an animal disease contagious to humans, and make a point of not eating infected meat (A. Powell-Cotton, interview 1988, Quex; E. Shamena, interview, 1989, FELM, Helsinki). The plant *eposa* **(Tinospora fragosa)** is made into a poultice for the boils, and *eposa* medicine is fed to non-infected cattle in the hope of making them immune (Loeb et al 1956:161, Rodin 1985:155).

Omukota/Omukona

The Finnish medical missionaries identified *omukota* as general bleeding and haemorrhaging of the body (Purpura) (Rainio 1922:28; Soini 1953:33). However, general haemorrhaging is normally known as *edjo lohonde (edjo:* outflow, discharge; *ohonde:* blood) (Turvey 1977). The term *edja omukota* specifically denotes heavy bleeding from the nose, although since this is very often the main visible symptom of purpura it may account for the preference of *omukota* as the illness name. The Powell-Cottons were given the

name *omukota,* and they were struck by the prevalence of the condition, especially in the Dombondola region (A. Powell-Cotton, interview 1989, Quex; notes for medicinal plant P-C.A36/2516). Aside from external and internal bleeding, symptoms are, not surprisingly, anaemia, fatigue, headache etc. It appears as though the blood of an affected person is perceived as being impure, or rather that there is *something* impure and disruptive within the body using the blood as a vehicle, and that removal is the main objective, since the main form of treatment for *omukota* is *sata* - blood letting. The body is covered in tiny cuts and the blood is allowed to flow freely. Unfortunately, however, the anaemic condition is increased this way.

Not much information has been recovered from other sources about this illness. Tomas Uukunde, of Ukwanyama, states that *olukona* is inner-bleeding (ELC 1932, item 87:216). Loeb calls the illness *omukoneko,* and describes it as "...hardened red excrescences appearing in the mouth or on the palms of the hands, and often there is bleeding from the nose and swelling from the body". He diagnoses the symptoms as being those of yaws (Loeb et al 1956:160).

Ongadgi

This condition is infertility and is frequently thought to be the result of cursing, or the wrath of an angered ancestral spirit. There are a number of cures available, involving plants which are symbolically associated with fertility and life: *omfiyati* is the tree of life and fertility (Loeb et al 1956:150), whilst the wild fig tree is symbolic of the ancestral spirits, its fruit and seeds ensuring female fecundity (Hopeasalmi 1946:61, quoted by Tuupainen 1970:46).

Oshivatu (K)/ Oshaatu (N)

This illness is known by several names, all fairly similar with the exception of *oshishi*. It is referred to as the 'illness of cramps' and it affects women in childbirth, perhaps even causing their death.[14]

These 'cramps' are actually the condition known as pre-eclampsic toxaemia, to which pregnant Ovambo women are especially liable (Tuupainen 1970:91). Tetanus and diptheria may also trigger off eclampsia.

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[14] The Ovambo believe *oshivatu* causes maternal death. The condition pre-eclampsia, which may be *oshivatu*, certainly causes hypertension, premature labour and placental insufficiency, which threaten the existence of the baby (Stoppard 1991:158, 162).

The Ovambo believe that adulterous pregnant women will be afflicted with *oshivatu*/*oshaatu,* the condition said to be caused by the fact that either the respective blood of the different people (i.e. the woman, her husband and her lover) is not at peace, or else the semen of the two men fight in the woman's womb (hence the cramps). The trouble can be avoided if the woman confides in an older kinswoman and undergoes ritual purification, either before or during labour (Tuupainen 1970:91-2; Gideon Iitule ELC 1932, item 104:237).

There is also a variation of *oshaatu*/*oshivatu* that affects men. The illness can result from two men sleeping with the same women, when one of the men happens to be wounded at the time. Without being ritually purified, these men will suffer epileptic fits and eventual death (Gideon Iitule, ELC 1932, item 105:238).

Oshithitikila

If a man has sexual intercourse with another woman (i.e. not one of his wives) whilst one of his wives is pregnant, then he may cause mortal danger to this wife and unborn child if he does not admit to what he has done. Should he remain secretive, his wife would be unable to deliver: "...the baby returns to her belly" and dies there, or else it is born dead (Tuupainen 1970:92).

Olusi

This illness is contracted by those who have sexual intercourse with a newly made widow, before she has undergone ritual purification. The widow herself will swell and die without being purified, according to Tomas Uukunde (ELC, 1932, item 86, 215). The semen of the woman's late husband is supposed to remain in her vagina, causing illness to her new lover (Loeb 1962:260). In fact, men having sexual relations with an 'impure' widow will see their "intestines rot away" (Loeb et al 1956:151).

Other Illnesses

There are a great many illnesses and conditions for which I have been unable to gather adequate information. Very often the name of the illness and the cure are present in the source materials, but only rarely are there Ovambo aetiological and pathological explanations. Examples are listed in Appendix 2.

Part 4: Causal Explanations for Illness and Misfortune

Recent and Current Anthropological Analysis

Indigenous aetiological thought has received considerable attention over the past two decades or so. The general tendency, until fairly recently, has been for researchers to follow the early definitions proposed by Clements (1932), classifying causal explanations for illness as belonging to one of three fundamental categories: (a) supernatural causes, (b) human causes, and (c) natural causes. In the particular case of African therapeutics, the literature reveals a decidedly heavy emphasis on the supernatural agents, combined with a relative de-emphasis of any possible natural causes. Human agency tends to be discussed within the realm of the supernatural, usually under the heading of sorcery or nefarious magic (Turner (1967) provides a good example).

Such (often overwhelming) bias in favour of the supernatural stems largely from Evans-Pritchard's influential analysis of Azande witchcraft - a phenomenon to which, he argues, all Azande illness and misfortune is ultimately attributed (1937). A good example of one who has followed in this vein is George Foster (1976), who argues that aetiology is in fact quintessential to the understanding of ethnomedical systems cross-culturally. He proposes two basic principles: 'personalistic' and 'naturalistic', that seem to him "...to account for most (but not all) of the aetiologies that characterise non-western medical systems" (1976:775). In a 'personalistic' system, illness is principally believed to be caused by the "active purposeful intervention of an agent, human (witch, sorcerer), non-human (ghost, ancestor, evil spirit), or supernatural (deity or powerful being)" (p775). Whereas the 'naturalistic' system, on the other hand, explains illness in rather more impersonal terms: thus disease is caused by natural forces or conditions (cold, heat, wind) and especially by an imbalance of the basic body elements.

African therapeutic systems have been assigned to the 'personalistic' system, with those of say India and China to the 'naturalistic' one (Foster 1976:775). Foster of course claims to be aware of the fact that such a broad, dual classification has its pitfalls, and admits that the two aetiologies are rarely mutually exclusive in society. Still, he maintains that most peoples are committed one way or the other.

Whilst on a very general, and perhaps even superficial level, Foster's argument may hold true, a

closer look at particular African societies reveals it to be at times on shaky ground. The problem, as I see it, lies mainly with what Foster calls the "overlapping elements", and the extent to which they occur in any given African society. Far from dismissing these, as Foster seems to, one ought to perhaps be considering them since they are after all an intrinsic feature of a given medical system. Moreover, it could well be that such "overlapping elements" epitomise the more subtle aspects of aetiological variation within Africa (and indeed elsewhere), so that cross-cultural comparison of them in addition to (or instead of) the clear cut features might yield the most interesting results.

For example, Harriet Ngubane's inspirational emic-portrayal of the Nyaswa-Zulu medical system shows that far from fitting happily into Foster's 'personalistic' category, Zulu aetiological thought strongly engenders both 'personalistic' and 'naturalistic' classification. Ngubane devotes a whole chapter to 'natural causes' of disease, whereupon biological breakdown of the body and ecological hazards, expressed in terms of imbalance, are all seen to play a part (Ngubane 1977:23-29). It is also true to say that the Zulu do stress the importance of supernatural causes, and that on occasion supernatural and natural causes may be interwoven, however this does not necessarily undermine the significance of those natural causes that do exist. In short, to ignore the 'natural' aetiologies in Zulu medical thought is to ignore much of their medical thought and practise, and the same can no doubt be said for other African societies.

Reassessment, even of supernatural-biased work, can yield interesting results. For example, Eva Gillies' reinterpretation of Evans-Pritchard's Azande material has shown that the Azande do actually recognise natural causes of illness, but that these are not so overtly expressed as those linked to witchcraft. Gillies blames the bias in Evans-Pritchard's analysis on the fact that he was less concerned with *how* disease happened (cause and effect), than with *why* it happened (i.e. witchcraft) (Gillies 1976:386-7).

More recently, John Janzen (1981:189), has proposed a much more embracing methodology for the study of African aetiologies. Rejecting what he calls the 'single-cause' approach (i.e. seeing all affliction as due to witchcraft), he favours the small but growing trend of viewing affliction as multi-causal. To accept the single-cause theory, argues Janzen, is to basically see African therapeutic systems as "closed". Multiple-causality, on the other hand, suggests an "open" system which is "....amenable to change at one or another level and to the accommodation of therapeutic pluralism". Janzen's reasoning is inspired by

Buxton's work on the Mandari of Sudan. Buxton has demonstrated that Mandari medical theory and practice have been open to change: European medical practices, for example, have been incorporated into the Mandari 'traditional' system where considered advantageous (e.g. surgical techniques). The important point here, is that Mandari and European medical beliefs and practices may sometimes co-exist (Janzen 1981:189), a feature which ought not to be ignored by researchers.

The approach adopted here, therefore, will be that Ovambo affliction aetiology is multiple rather than singular in character, although the degree of emphasis attached to each particular causal explanation may vary. For instance, natural causes are certainly acknowledged and deserve recognition, but they may not be regarded as being so important as those that are supernatural. In the past such less explicit natural causes have been described as secondary to primary causes, such as witchcraft. Orley (1970:138), for example, states that among the Ganda epilepsy may be caused either by a lizard or by sorcery, but that the lizard may be sent by the sorcerer

This apparent dual-level aspect of causality has been recognised by Foster as a characteristic of 'personalistic' systems (in 'naturalistic' systems the levels are depressed or non-existent), whereupon the ghost, deity or witch is the "efficient cause" (i.e. the primary one) and the instrument or technique used by that being (i.e. possession, soul-theft, poisoning) is the "instrumental" or the "immediate cause" (i.e. the secondary one) (Foster 1976:778). Foster does not directly refer to natural causes in connection with this (since it would interfere with his neat dichotomy). However, one could assume that they would be found in the second of the two categories (cf Orley above).

The notion of levels itself is intriguing and (although perhaps not Foster's intention) goes part way towards overcoming the limitations posed by a strict 'naturalistic' versus 'personalistic' dichotomy. For instance, when considering 'primary' and 'secondary' causes, Janzen (1981) believes that although the two groups are not mutually exclusive, they are still well defined enough to be differentiated from each other. That is to say, secondary causes do not have to be subsumed to a great extent, but can be viewed as independent, albeit related, categories. Thus: "To attribute misfortune to witchcraft does not exclude the 'real' causes: it is merely superimposed on them and gives social events their value" (1981:188). Janzen goes on to suggest (on the basis of Ngubane's Zulu material and his own Kongo data) that it is possible to have an

aetiological continuum, with God and humans at either end and a whole range of aetiologies in between: personal disregard for health/diet, antisocial behaviour, spirit-related causes and so on. 'Nature' is equated here with God, and human cause is defined as people being at odds with each other, expressed in terms of witchcraft and sorcery (Janzen 1981:190).[15]

Another important issue in the evaluation of aetiological thought is the assignment of the cause. Orley (1970) has argued that it may be too simplistic to assign one particular cause from the range available to one particular disease, because aetiologies vary in connection with the perspectives of those involved. That is to say, neighbours may hold one opinion, afflicted persons and their families another, and healers still another (1970:140). The opinion of the healer is the one which is normally respected. It is worth bearing in mind that a range of lay beliefs may coexist at any one time.

Linked to the issue of aetiological assignment is the distinction made by Loudon (1976:36) between disease as either exopathic (from the outside) or endogenous (from the inside). In some analyses of ethnomedical systems the inside/outside dichotomy may serve to enhance the aetiological continuum (assuming there is one) - providing another dimension or perspective. The concepts inside/outside are of course culturally variable, and thereby an analysis of disease aetiologies in these terms ought to yield interesting results. Sadly the Ovambo information is extremely scanty on this point; Shivuta does mention that the Ovambo perceive an agent of illness to be something which exists outside of a person's body (Shivuta 1981:4). Certainly illness appears to be associated with the area outside of the household, i.e. the bush, and subsequently with beings thought to reside there: wild animals, ancestral spirits and witches. Lebzelter mentions that rheumatism is known as 'Herero-land sickness', and this most probably refers to the fact that the illness was contracted by men who had migrated to this more southern part of Namibia to work on the farms of Europeans (Loeb 1955a:37).

Finally, a word of caution from Gilbert Lewis. He warns that it may be misleading to be preoccupied with disease aetiologies, mainly because:

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[15] Comaroff's (1982) view is that disease is essentially 'natural', but an overwhelming dose of it. This means that recourse to the 'supernatural' is needed to restore the balance. For more on God = Nature, and Witchcraft = Social problems, see Osei (1975).

> "....the very fact of no explanation, or of neglect, might be a distinctive cultural feature in handling illness in a society, and significant for the understanding of its cosmology and the values set on health, or social attitudes towards status or roles" (Lewis 1975:2).

Ovambo Illness Aetiology

The bias towards supernatural causes of illness that has been seen to dominate much of the ethnomedical literature for Africa, can also be found in many of the sources relating to the Ovambo. For example, according to Loeb (1955a:43): "The Kwanyama believe that the three varieties of sickness are those coming from the high God Kalunga, those from ancestral ghosts and those from witches". All three are presumed supernatural, an assumption which is later referred to explicitly by Kyronseppa (1970:3), who states matter of factly that "...the Ovambo have no beliefs in natural causes at all, just spirits, witches and Kalunga (God)".

A survey of published and unpublished sources has revealed that the above statements are largely, but not entirely, representative. To be sure, supernatural causes tend to dominate Ovambo illness aetiology, but there are other aetiologies available which seem to have been overlooked or discounted by scholars like Loeb.

Justina Shivuta (1981:2) mentions that illness and unhappiness are mainly caused by spirits and witches, but gives some other examples as well. Sudden illness, for example, is thought to be the result of cursing. Illness may also befall people who transgress precepts or prohibitions. Those illnesses that are perceived to be incurable or unusual (like ascites), are said to be caused by Kalunga (God) and healers are not normally consulted. The association of Kalunga with incurable or strange illness is a feature of Ovambo medical belief that has been noted by others. Brincker, for example, writes that:

> "Only those peculiar and unhealable wounds, as cancer, tuberculosis of the bones, festering sores, and the like are *oipute,* which Kalunga has sent out of the basket of bad fortune, and which attack people as a sign of special disfavour. Such a person is marked out and avoided by everyone, for he belongs to kalunga. But he is taboo and is never molested or killed" (Brincker 1899, English trans. in Loeb 1955a:43).

Dropsy, another inexplicable illness, is also believed to have been sent by Kalunga. Indeed the Kwanyama

name for the condition is *oufimba wa Kalunga,* meaning literally ‘pregnancy from God’ (Estermann 1976:183; Loeb 1955a:38).

When referring to an ill person it may be said that: (a) ‘the spirits of the ancestors have bitten him’, or (b) ‘the evil eye has looked upon him’, or (c) ‘he has been talked about’ (Shivuta 1981:2). The notion of ancestral spirits causing affliction by ‘biting’ their victims, is consistent with similar notions of ‘eating’, ‘biting’ or ‘devouring’ which occur in many other Ovambo illness aetiologies. Soul-loss, for instance (caused by witchcraft), is expressed in terms of the liver (the repository of the soul) being violently devoured by a witch (in the guise of an owl) at the top of a large wild fig tree (Hiltunen (1986:65). Although not strictly an illness, being more of a depressive symptom, sadness is described as something which "eats" at the heart (a shock being a "bite" into the heart) (Turvey 1977).

With regard to a person becoming ill from being ‘talked about’ (Shivuta 1981:2), this is most probably a reference to sorcery, and to cursing in particular. Sorcerous acts usually involve pronouncement of the intended victim’s name. Personal names, along with saliva, blood, excreta, semen, urine and sweat, are regarded as a sort of mystical extension of one’s soul - hence their appeal to sorcerers (Aarni 1982:68; Hiltunen 1986:131-132).

The Ovambo evidence does not appear to support a strict supernatural:natural dichotomy, revealing instead *some* cases of natural and *some* of supernatural character, along with *many* cases where the two areas can be seen to overlap[16]. For this reason Janzen’s multi-causal theory for illness aetiologies seems most appropriate in the Ovambo context.

To give an example, two of the most prominent illnesses of children: *(onjudi/onjundu* and *oudu odila)* are both believed to be directly caused by certain birds, so would therefore appear to have natural explanations. Moreover, *oudu odila* can also be caused by the wind on occasions when the *onghombe* bird is not an appropriate explanation (D. & A. Powell-Cotton 1936/7a:7). However, at this point we need to consider Ovambo definitions of ‘natural’ in the context of illness aetiology. There has been an attempt made by Orley (1970:140), to classify ‘natural’ causes of illness for Africa generally. His conclusion was that

[16] This to an extent contradicts Foster’s theory of mainly supernatural or mainly natural, with only some overlapping.

identifying such causes can be problematic - basically because what anthropologists define as natural may not correspond with the definitions of the people themselves, and vice-versa.

Shamena has offered what (at face value) appears to be a purely natural explanation for stomach illness, fever or fits. He suggests that piles of fine grit which are allowed to build up in the stomach will have detrimental effect (interview, FELM, Helsinki, 1989). The grit finds its way into the flour during the pounding process, and subsequently into food such as porridge.

On the whole, however, it appears that a great many animal species are accorded at least special, if not supernatural, qualities by the Ovambo. Certain birds of prey belong especially to this category. The *kaimbi* (Yellow billed kite), for example, is believed to destroy precious rainclouds, behaviour which is interpreted as a sign of ancestral dissatisfaction.

The *epumhumhu* (Ground Hornbill) is considered an extremely sacred bird, known often as the "bird of Kalunga" (Estermann 1976:203). The *epumhumhu's* gloomy, sonorous cries are taken to be a portent of doom: namely the imminent death of someone important. Any man who kills such a bird must undergo immediate ritual purification (Loeb et al 1956:). The piercing cries of eagles are commonly believed to be the voice of Kalunga, and can be interpreted only by diviner-healers (Moller 1899:119, Eng.trans in Aarni 1982:105). The wood carvings of the Tchokwe, a neighbouring pastoralist people in central Angola, often depict Kalunga either as a bird, or in association with one (Aarni 1982:105).

The *ekula* (owl) is normally associated with witches, and indeed may be inhabited by the latter when they travel the bush searching for possible victims (Hiltunen 1986:65). Since the owl is a nocturnal creature its association with malevolent forces is not surprising. Natural phenomena credited with supernatural or special characteristics are not always classified as being malign, however. One example of benign association is to be found in the symbolic link between diviners and crows. The calabash musical instrument used by diviners is called *ekola,* also the name for a crow. Diviners often wear a headdress of crow's feathers. It is unclear, though, who (or what) the crows particularly represent. Certainly the rasping noises emmanating from the *ekola* are supposed to be the voices of the ancestral spirits, so perhaps it is these. There may be some significance also in the fact that the crow is pure black in colour, since black is regarded as the most prestigious and important of the range: it represents the ancestors, rain, rich earth, wealth and high social

status (chiefly royal status).

Birds are a central feature of the circumcision ceremony for boys. The actual period of initiation is organised by 4, 6 or 8 men dressed as birds: they wear bird masks and netted costumes sporting feathers. These 'bird-men' are called *okangadi*. The process of initiation is itself likened to being swallowed by a bird (again we have a notion of 'eating'), and then being passed out of its anus. Any boys dying during this period are thus said to have remained in the bird's stomach. The humming noise of the bullroarer used during the occasion, is supposed to be the voices of birds (Loeb 1962:236-237). Incidently, during the female *efundula* ceremony among the Ombadja, a kudu horn is blown, and this too is said to be bird cries, Loeb adding that they represent the voices of the ancestral spirits (Loeb 1962:269).

There are numerous other examples of wild creatures possessing supernatural attributes, and it is impossible to list them all here. It is worth stating, though, that whereas some creatures seem to enjoy immutable supernatural association, others do so only in certain circumstances. For example, the *epumhumhu* bird is always considered sacred. Likewise, so are sheep *(odi)* - partly because of their gentle nature, but mainly because they were (together with fire and water) the first gifts from Kalunga to the 'first' Ovambo people (Loeb et al 1956:170). Particular cattle (i.e. the first to comprise a herd) are another example.

As for mutable supernatural association, animals, birds, insects or reptiles found in particular locations at particular times may enjoy such status, otherwise being just natural. To give some examples: a dead mouse found in a household is considered an omen of death, a praying mantis *(efingue)* discovered in the household indicates marriage breakdown, and so on. There are some species of snake which indicate misfortune, whilst others herald good fortune (Loeb et al 1956:171). Finally, of course, one should not ignore the many plants, animals, birds, reptiles and insects which hold totemic value.

It seems probable that the Ovambo equate Kalunga with the natural sphere (for instance , as the Zulu and Kongo do [Janzen 1981]), rather than with the realm of the supernatural (the case proposed by Foster, for Africa generally (1976)). Certainly Kalunga is associated or identified with so called 'natural' phenomena - and is indeed the source of power influencing their existence. Kalunga is regarded as being a rather remote deity, and is usually thought of as some kind of androgenous being. Kalunga is also 'fate', in the

sense that things beyond human control are attributed to Him-Her, and are received with resignation as being 'the will of Kalunga' (Aarni 1982:121). Although Kalunga may be conceived of as an anthropormorphic being, He-She is nonetheless invisible to the average person. So when Kalunga strolls through the land distributing fortune and misfortune from the benign and the malign baskets tied around the waist, His-Her presence is felt rather than observed. Or rather Kalunga may be observed, but as a natural phenomenon not as a physical human being as such.

Examples of the kind of natural phenomena representing kalunga's presence include those that are considered unusual, inexplicable, exceptional and perhaps frightening: thunder and lightening storms, birds of prey, rain, drought, pestilence, illness epidemics, incurable or inexplicable diseases, twin and breach births, albinos and hermaphrodites.

Ancestral spirits may also be associated with natural phenomena, albeit to a lesser extent then Kalunga. For example, light breezes are considered uneventual but high winds, or the arrival of wind in a particular place at an auspicious time, are believed to be an indication of the presence of ancestral spirits. Indeed, *omhepo* is the noun referring to wind or the air generally, to breath, and to the ancestral spirits. The wind which rustles the sacred groves of *omufyati* **(Colophospermum mopane)** is a kind of physical manifestation of the spirits: a form of communication with the living at the group level[17]. For example, the male circumcision ceremony cannot commence until a high wind *(omhepo ihapu)* blows through the groves - a sign from the spirits *(ehepo)* that the right time has arrived (Loeb 1962:237). Similar high winds are ritually summoned during cattle raids by the *ondyai* (ritual war leader) to aid an attack by provoking fear and confusion in the victims.

Since ancestral spirits can be personified by a high wind on certain occasions, when an *ondudu* thus claims that *oudu odila* can be caused by the wind, does he mean the wind as a natural phenomenon or the wind as a metaphor for ancestral spirits? Whilst the available evidence is sufficient to suggest the question, there is unfortunately not enough information to provide an adequate answer. Nonetheless, this example serves to emphasise the need to allow for the possibilty of different kinds of categorisation existing in illness aetiology.

[17] Illness and dreams are the most common ways in which ancestors communicate with individuals.

Contagion

Any discussion of indigenous illness aetiologies really ought to include any explanations based on the idea of contagion or infection, although strangely enough this is an aspect of aetiology that seems to be absent in much of the ethnomedical literature pertaining to Africa. As with the categories 'natural' and 'supernatural', the cultural definition of 'contagion' varies from one place to another. Orley (1970:148) has indicated that what the Ganda classify as being contagious the western biomedical perspective would not. The notion of contagion, declares Orley, confuses the "...classification into 'come by themselves' and 'sent by another'". Furthermore, it is worth appreciating that with the advent of Europeans, indigenous and western notions of contagion have become somewhat mixed.

Certainly in the case of the Ovambo, there are terms for contagion and infection, although it is difficult to say for sure how unadulterated these terms are. In other words, the terms may or may not be the product of European influence. Nevertheless, many aspects of Ovambo belief and practice dealing with illness suggest that notions of contagion certainly existed prior to European influence.

One illness which exhibits such contagious qualities is *oudu odila*. Children appear to catch the convulsions from the bird as it flies over them. *Onghombe* birds are not instruments of other causal agents such as sorcerers or witches, they 'come by themselves', to use Orley's phrase. The similarity between the child's convulsions and the bird's flight pattern is very striking, so it is hardly surprising that these two are closely associated in illness aetiology. The notions of contagion that seem to characterise causal explanations of illness are not too dissimilar, in principle, from those which characterise the mechanics of sorcery and certain therapeutic practices. Orley, however, has cautioned that "..the true mechanism of contagion is rarely stipulated, if indeed at all" (1970:140).

The actual idea of contagion is expressed in terms of pollution or impurity - something present in the body which is considered undesirable and which must be (ritually) removed. Persons in a state of impurity are believed to be able to transfer their polluting qualities (in the form of misfortune) to others, hence the emphasis on segregation and cleansing during healing. Bodily substances are classified as being extremely contagious material, and as such are highly desired by sorcerers. The semen of a recently deceased husband remaining in the vagina of his widow, is believed to be dangerously contaminating to any new lover (Loeb

1962). Ideally all physical residues (i.e. semen) and psychological bonds must be ritually removed *before* the widow takes a new lover, so that contamination does not occur.

Anthrax, the serious contagious disease of cattle, is recognised by the Ovakwanyama in that they will not eat anthrax-infected meat. Also, non-infected cattle are segregated and given preventive medical treatment (Loeb 1956:161). It is difficult to ascertain whether or not European advice has had any bearing on the non-consumption of infected cattle meat. It is the only occasion when cattle meat is 'wasted', since those dying from tuberculosis and other diseases are eaten. In any case, there are other ways of contracting anthrax, as mentioned in Part 2.

The causes of illness are experienced in one or more of the following three ways:

[1] Disease-object intrusion (i.e. poisoning from sorcery, arrows from witchcraft, natural things like thorns or grit).

[2] Spirit intrusion *(i.e. akwamungu, ohula).*

[3] Soul-loss (witches stealing it, depression).

These categories are essentially those proposed by Clements (1932), and are what Foster classifies as "immediate or instrumental causes", the manifestations of "efficient causes": witches, sorcerers, God, natural phenomena etc. (Foster 1976:778).

The distinction between the pathogen (the actual disease causing agent; the "efficient" cause) and the aetiology (the philosophy of causation) is not always apparent in Ovambo explanations for illness. For instance, the Ovakwanyama use the word *oikupa,* which is a name for the cause of disease - in this case poisoning. Removal of the *oikupa* (cause) is known as *kufu oikupa,* and refers actually to anti-sorcery ritual. So, are Ovakwanyama referring to the pathogen or to the aetiology: the efficient or the instrumental causes, when using the term *oikupa?* Perhaps it is not always possible to detect the primary and secondary levels of aetiology which Foster talks about. It may also be, of course, that such levels do not always exist - or even that the aetiologies themselves do not (Lewis's point, 1975:2).

In general terms, illness seems to be conceived of as something intrusive more than as something which is lost or extracted. This is reflected in the types of medicines employed, almost all of which are

concerned with the expulsion or evacuation of something alien and detrimental to the body. Of course the replacement of something lost is also an important feature of Ovambo therapeutics, but this form of treatment is much less emphasised.

Summary and Conclusions

The people of Ovamboland are prone to most (but not all) of the diseases typical of tropical Southern Africa, although it is clear that the effects of European colonialism - felt mainly through war, migrant labour, South African and Portuguese policy, and European presence in general, have all either initiated or significantly exacerbated many of the health problems in the region. Comparatively early evidence from the medical missionaries in northern Namibia, has indicated that many of the serious diseases such as TB and VD were virtually unknown to the local population before 1900. From about 1920 onwards, official statistics and the opinions of medical personnel based in the northern clinics reveal an alarming upward trend in the number of cases diagnosed. Soon TB and VD became, along with endemic malaria, the chief scourges of the Ovambo peoples.

With respect to Ovambo beliefs and practices concerning health and illness, there is sufficient evidence to show that the Ovambo value health and are concerned with maintaining health standards. Effort is made to keep the living areas and the immediate environment essentially free from human waste, and considerable attention is devoted to personal hygiene and general appearance, including oral health.[18] In general people attempt to conduct their lives in such a way as to not attract illness or other misfortune. That is to say, people seek to avoid anti-social conflict or breaking prohibitions, and try to be involved in regular propitiation of the ancestral spirits. Protective measures are also taken against other malign forces, namely the use of prophylactic charms. Such measures, however, are not always effective, and a variety of causal explanations exist for the particular illnesses which result.

The Ovambo appear to regard illness as a special category of misfortune. In fact illness can be viewed as being the experience of misfortune at the most personal of levels, even when manifested on a

[18] It is certainly possible that the Ovambo might conceive of personal hygiene and orderliness as either *aesthetic* or *humanness*, rather than as a practical way of maintaining health (an observation of M. Last). However, I have no data which suggest that either (or both) of the above alternatives may be the case - except perhaps for the (aesthetic?) practice of covering *ehumbo* floors with fine, white river bank sand rather than the original coarser stuff (see p51).

public scale (i.e. an epidemic). Illness, in any case, rarely affects the afflicted individual alone, since family members, kin, neighbours and the healers themselves are all involved to varying extents.

Illness is expressed in terms of disorder and lack of harmony - it signifies a departure from a healthy state of being which is fundamentaly regarded as being the 'norm'. Once placed in such an abnormal state, the afflicted individual (and his/her family etc) is rendered particularly weak and vulnerable, with the effect that a return to the desired healthy state is usually sought quite quickly, and perhaps at considerable expense if the illness is serious. Certain of the healers' actions, together with some of the medicines they administer, are specifically concerned with strengthening and they either follow, or are combined with, restorative treatment.

One of the ways in which the Ovambo cope with the disorder affliction creates, is to name and classify particular illness patterns or symptoms and assign to these causal explanations. By organising illness in this way some attempt is being made to impose some kind of conceptual 'order' on physical disorder, with the ultimate aim of thereby controlling it. Turner has made a similar point when talking about Ndembu therapeutics: the healers are concerned with making disease 'visible' and thus tangible, so that it becomes less frightening and thus more manageable (Turner 1967:302-303).

Ovambo nosology can be summarised briefly as follows: specific illnesses may be named, (a) according to the type of relevant treatment, (b) according to the particular body part or area affected, (c) according to the effects of the illness or to the chief symptoms, or (d) according to the particular causal agent(s).

The classification of causal explanations by some social anthropologists into either natural or supernatural categories - African theories being almost always assigned to the latter group - is found to be rather misrepresentative of actual situations. The alternative view, which is accepted here, is that which sees illness as being multi-causal in character (Janzen 1981). There are a growing number of studies of health and illness in Africa which tend to support this claim, and evidence for the Ovambo suggests a similar situation may be the case.

Comaroff has said that illness essentially represents "...a partial or total eclipse of man's social being by his natural state" (1982:51), so that this often needs to be answered by a recourse to the supernatural (i.e. contact with the spirit world, 'magical' treatment etc), in order to restore harmony (Jervis, unpublished

MS): "Healers everywhere manipulate symbolic media which identify physical with social order" (Comaroff 1982:52). Not only does this apply to the practical methods of dealing with illness, but it applies to illness aetiologies as well. For example, illnesses have been found to have often more than one cause, known as either 'primary' and 'secondary' causes, or as 'effective' and 'instrumental' causes. Usually it is the supernatural agents which are identified as being the 'primary' and 'effective' causes, with the other two groups being characterised by the more 'natural' phenomena. The perspective of Janzen is adopted here, whereupon the 'secondary', 'instrumental' or 'natural' causes amount to what are in effect the *real* causes of illness, and where the 'primary', 'effective' or 'supernatural' causes are the *surreal* causes - they form the 'why?' level of explanation. In short, witchcraft sorcery, divine retribution and ancestral wrath act as fuller explanations for affliction. This is why minor illnesses, which are not considered particularly threatening, are not usually explained in relation to the supernatural; they are given a 'natural' explanation or simply none at all. However, when illness is particularly acute, becomes chronic, or will not respond to therapy, then supernatural explanations are sought (Ackerknecht 1946).

It is not always easy defining what is classified as being strictly 'natural' in Ovambo terms, since certain categories (e.g. birds) may be 'natural' in one context, whilst in another assume supernatural or special qualities. In other words, the categories appear to be mutable rather than fixed. Extraordinary 'natural' phenomena: lightening, floods, drought, twins, albinos etc, are commonly regarded as being tangible manifestations of the presence of Kalunga ('God') and the ancestral spirits.