

6. STDs, suffering, and their derivatives in Congo-Zaire: notes towards an historical ethnography of disease

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*“the split references to the sufferer as both a victim
and the one responsible for her own fate
act as shears through which suffering is sought
to be cut off from the victim to become the child
of the pronouncer of this discourse” (Das 1994: 141, 162)*

In 1978, Anne Retel-Laurentin published a memoir about her experiences as an outsider, doctor, anthropologist, and white colonial lady in French equatorial Africa in the 1950s. This pioneering French medical anthropologist, who did fieldwork among Nzakara men and women suffering from the sequelæ of STDs in present-day Central African Republic, transformed herself into an historian of marriage and the exchange of women before she had completed her remarkable analysis of the social epidemiology of Nzakara subfertility (1974; 1979; Biraben 1987; Hurault 1987). In the midst of her 1970s recollections, she included a dinner scene in Bangui, where French colonial officials quizzed her about her research topic as domestic servants circled the table with wine. Her narrative suggests, therefore, that this sumptuous colonial dinner where French men blamed Nzakara infertility on their lazy men and loose, self-aborting women was hardly incidental, but rather an integral part of the social field in which she studied (1978: 118-24). Moreover, I remain haunted by Retel-Laurentin’s canny words about the way she was received in one Nzakara household by a young married couple who had been unable to have children: “ce jeune ménage bien portant mais stérile,” she said, “qui m’avait accueillie comme un dérivatif à leur ennui” (1978: 113). They welcomed her, she said, as “a derivative to their tedium.”

I have found that it is not possible to study medicine and colonialism in Africa and not also feel like a derivate to others’ pain and affliction, a derivative to an historical experience of overrule, misfortune, disease, bodily intrusions, and (whether literally or figuratively) infertility. My fear of being one more parasitic, foreign,

'derivative'¹ of the suffering of the people in the African country I know and love best has kept me up to now from writing about the AIDS crisis there, never mind finding myself, not unlike Retel-Laurentin at a dinner in Bangui, at a luxurious remove within Africa from the human suffering caused by a sexually transmitted disease among the poor. Anne Retel-Laurentin, of course, spent years in the trenches of Nzakara suffering, and many researchers were gathered at the Sali Symposium from social realities of those dying in their countries of birth and adoption. My research itinerary has been a more comfortable, shielded one, arriving as I do in Sali Portugal from the safe remove of archives and libraries in the West, and drawing only obliquely from my fieldwork on fertility along the Upper Congo in 1989-90.

The pain of barrenness was a frequent subject of conversation during these fourteen months, but only once while living in a village thirty miles downriver from Kisangani did I overhear a conversation about AIDS. The visit of a well-dressed city woman from Kinshasa inspired this conversation among a few women paddling home from the nearest market town by canoe. The Kinois warned her village sisters against their desire for city life and fancy clothes. She, like her interlocutors, was barren, she explained, though now this humiliation was combined with the dread of AIDS funerals and the anxiety of vulnerability, knowing as she did that her husband sought children and pleasure elsewhere. The implication of this 1990 conversation was that rural Zairian women knew not the compounded distress of a barren, city woman living in an era of AIDS. The critical difference among these women was not vulnerability to AIDS, of course, but consciousness of the sexually transmitted nature of this disease. It is the links within this entanglement of infertility, shame, and the production of STDs consciousness that I wish to quarry in historical terms here.

Untidy histories

I am not the first historian to look at how sexually transmitted diseases intervened in human history in an attempt to draw social meaning for the present crisis over AIDS (Fee and Fox 1988; Packard and Epstein 1991; Vaughan 1992: 299; Arnold 1993; Berridge and Strong 1993; Brandt 1993). Their number permits speaking of a genre, an important genre.² Many are a variation on a single theme: the historical reconstruction of AIDS as a shameful sexually

¹ On the numbers and dangers of foreign-funded, foreign-directed research projects on AIDS in sub-Saharan Africa, see Obbo 1995.

² A recent conference, organized by Karen Jochelson, Institute of Commonwealth Studies, University of London, 'Comparative perspectives on the history of sexually transmitted diseases' 26-28 April 1996, included several Africanist contributions. See, too, Philip SETEL, Milton LEWIS and Maryinez LYONS (eds), *Histories of sexually transmitted diseases and HIV/AIDS in sub-saharan Africa*, Westport, Greenwood Press, forthcoming.

transmitted disease of racialized, promiscuous sexuality (Fee 1988; Packard and Epstein 1991; Vaughan 1992). Randall Packard and Paul Epstein (1991) have lucidly pointed to the consequences of this historical repetition on AIDS research in Africa. The immediate and unmediated research assumption that the primary mode of transmission of HIV in Africa is promiscuous, heterosexual sexuality quickly foreclosed research on other likely factors —unsterilized needle use, blood transfusions (especially for pregnant anemic women), and structural inequalities— while research agendas zeroed in on prostitutes, multiple partner sexual behavior, and condom use. Still, as important as it is, Packard and Epstein's study joins the others in considering the imposition of meaning and representations, moralities and causalities from above —from Europe, from Atlanta, from the Bible, from the side of doctors, international funders, and state regimes. Historians, like most social scientists, have not tended to consider with the same depth the meaning-making and suffering of those afflicted by sexually transmitted disease.¹ We still know far too little about local, popular epidemiologies and therapeutic practice —in the broadest senses of these terms— evoked by AIDS in Africa.

I began by seeing my task as one of finding parallels, antecedents, perhaps inversions and paradoxes, but certainly history as a genre of knowledge that was *out there*, an object that I must constitute, but once constituted as story, would provide *lessons* for the present: a useful past, therefore, to share with policy makers, health care practitioners, and researchers. The more I worked, however, the more I realized that regardless of audience, history need not be seen only as *history for* (someone else). History also *lives* in social memory, in institutions and structures, in the ordinary ways that the afflicted make meaning out of survivals, repetitions, and novelties, out of old injuries and new diseases. Even so, my task proved not easy. I collected piles of evidence on STDs in colonial and post-colonial Zaire, including the readily available published AIDS literature —doctors' research, medical reports, official proceedings, missionary pleas, mining company statistics, even some memoirs, hygiene handbooks, and poems. Yet there was no easy shape to these piles. Both the colonial STDs one and the post-colonial AIDS one produced the same frustration: how exceptional the clues were about the experiences and meaning-making of local people.

When turning to the history of STDs in colonial Zaire, I discovered that if I retained a notion of an epidemic as a 'critical event' (Das 1995) with 'dramaturgic form' (Rosenberg 1992: 279), no plot —not even a top-down, colonial-inscribed story— came easily tumbling out. Instead, I found chaos in reporting, in statistics, in a sporadic clatter of opinion and interventions. Not that there were no attempts to impose meaning on venereal disease (VD) in the Belgian Congo. When

¹ For exceptions, see Farmer 1992; Hagenbucher-Sacripanti 1994; Obbo 1993, 1995; Weiss 1993; and Setel 1992. I do not question the value of more action-oriented research methodologies (e.g., Schoepf 1991a, 1991b, 1993; Preston-Whyte 1995), though their exclusive use does seem to come at the cost of ethnographic depth.

colonial authors wrote hygiene books for Congolese school-going youth, they immediately called them *maladi ya aibu*, ‘sicknesses of shame’ (Manuel 1931). Yet, unlike in Northern Rhodesia among the Ila (Johnson 1993; Vaughan 1992), Tanganyika among the Haya (Larsson 1991), and Uganda among the Baganda (Summers 1991; Vaughan 1992), there was never a sustained, focused panic about syphilis as moral dissolution in the Belgian Congo. A demographic and moral crisis over depopulation was a major ‘social question’ in the 1920s, and a fertility crisis among the Mongo (Nkundo) heated up from the 1930s (Hunt 1993). But was venereal disease represented as principal causality? No, Belgian colonial logic was more diffuse, more psychological (with, so the logic went, the shock of colonialism leading to ‘race suicide’ and unwitting ‘neo-Malthusianism’), and more influenced by a Catholic pronatalist stream of thought that focused on willful abortion, promiscuity, polygamy, postpartum abstinence, and positive eugenics (Hunt 1988; Hunt forthcoming).

Statistics on numbers of cases went up as medical care was extended in the colony, yet no one ever suggested that the numbers of Congolese patients treated had anything to do with the number of actual cases. Treatments, too, had little to do with cures. Here the patients were blamed. Congolese were not coming back for injections as they should (RBCB¹ 1925-58, e.g., 1930: 54-58). Syphilis cures seemed “so rapid that the sick come without difficulty” (RBCB 1926 15-16). Gonorrhoea was ‘widespread’ from at least 1925, but ‘difficult’ (RBCB 1925: 13; 1927: 11; 1932: 30-31) and sometimes too costly to afford for ‘natives’ (RBCB 1929: 28-29). In one *chefferie* near a railroad line in Mayumbe, 76 percent of the male population had gonorrhoea (Cocq and Mercken 1935). Colonial doctors understood gonorrhoea as “one of the big causes of a low birth rate among natives,” though the numbers treated only represented “a fraction of real cases because female gonorrhoea escapes in large part medical control” (RBCB 1934). Gonorrhoea rates declined significantly among Europeans, however, as the numbers of infected Congolese grew. Indeed, anti-VD work among Congolese often was focused where European contamination was most at issue, as a Red Cross VD clinic in Leopoldville demonstrated (RBCB 1932: 30-31).

There is almost a complete absence of evidence in colonial medical reports on how Congolese subjects experienced and interpreted STDs and their treatment. Scattered sources suggest, however, that local forms of treatment were common (Spire 1922; Vos 1973); colonial doctors combined syphilis investigations with sexual desire into the post-World War II period (Lambrecht 1991); and miscarriage-provoking and hereditary syphilis often went untreated (Vos 1973). In some areas, however, Congolese women sought out neo-salvarsan injections after a miscarriage (Cocq and Mercken 1935). Indeed, the evidence suggests a movement of suffering female bodies damaged from the sequelæ of gonorrhoea, who willingly lay down under surgical

¹ RBCB abbreviates: Royaume de Belgique, Colonie du Congo Belge. *Rapports sur l'hygiène publique*.

lights for colonial doctors in search of renewed capacities to conceive babies and have children (Dubocage 1934; Guillot 1930; Lambillon 1948, 1957; Vander Elst 1946).¹

During the Congo Independent State years (1885-1908) until after World War I, European colonial life was overwhelmingly male. Medical reports indicate that the focus of hygiene attention was European agents and the first colonial categories of stabilized labor, soldiers and other state workers. The frequency of venereal disease was “regrettable” but “almost inevitable ... in a country where love relations are so inconstant and fragile,” wrote one colonial doctor in 1909.² Dr Veroni was speaking about Europeans as much as anyone else. Indeed, doctors encouraged European men to take Congolese concubines, steady, sanitized lovers known euphemistically as *ménagères* (housekeepers). In 1906, after a river steamer passed through Basoko, an outbreak of STDs emerged among Congolese workers in this state post. The doctor complained, suggesting that if European steamer personnel and passengers “could travel with their *ménagères*, perhaps we could avoid the transmission of these noxious diseases in the posts served.”³

In 1909, the first legal measures to regulate prostitution were taken in the colony. All women who ‘habitually’ and ‘notoriously indulge in prostitution’ in designated European centers became obliged to undergo police investigation proving their status, have their names entered in a police register, carry special medical cards, and undergo bi-weekly medical exams; if found diseased, they were to be ‘interned’ at the hospital until cured. A 1912 circular declared that venereal disease, especially syphilis, was creating “true ravages among the populations of the Colony,” reminding authorities of the 1909 prostitution ordonnance: “It is by the prostitution of black women, especially, that these diseases are propagated. It is therefore against prostitution that the efforts of authorities must be directed” (Congo Belge 1912: 416).

By the early 1920s, venereal disease no longer looked so simple. More and more Congolese men were responding to industrial and commercial propaganda attracting them to work in large mining centers and cities. These ‘pseudo-civilized agglomerations’ were sites of ‘shamelessness.’ Large numbers of men were living together without families or adequate medical care while prostitutes catered to Congolese men (*Conseil Colonial* 1923), and European and Congolese men competing over Congolese women’s bodies (Higginson 1989: 64-66; Vellut 1992). More, venereal disease was not only an important cause of morbidity and mortality, but of ‘depopulation.’ There was a period of acute sense of demographic crisis in the 1920s, when

¹ A more detailed history of STDs in Congo-Zaire is in progress; the following summarizes some major points.

² Dr Veroni to M. le Gouverneur Général, 4 January 1909, H (841), Archives Africaines, Brussels.

³ Rapport sur l’hygiène du 3^{ème} trimestre, 1906, H (834), Archives Africaines, Brussels.

venereal disease was invoked alongside a myriad of other problems related to family formation and deformation in the colony —labor migration, polygamy, licentiousness, a declining birth rate, postpartum abstinence practices. For the first time, obligatory medical care and reporting of the diseases extended beyond Congolese prostitutes to anyone with venereal disease.¹

Mining companies began to see it in their interest to invest in the social health of its workers. Union Minière, for example, decided to stabilize labor in the mid-1920s. Rather than continuing to depend on an unprotected labor force of men without wives and families, they decided to enable their workers to marry by extending bridewealth payments to them and providing housing, health care, and social services for monogamous families under their tutelage and control. This was, in part, a clean-out-the-prostitutes, clean-out-the-VD campaign. Within Union Minière's mining compounds, it may be fair to speak of an epidemic with dramaturgic form, but reducing VD among skilled miners and their families was only one strand to a more complicated, company-engineered plot. It was also one of providing good diets for workers, improving health and survival, and importing women as monogamous wives to reproduce this labor force including, quite literally, giving birth to the next generation in company-operated maternity wards. It was, in a word, a situation of intense social control, where the incidence of VD declined alongside morbidity and mortality rates. Not that there was no moral purity campaign at work in this campaign. Assumptions about African sexuality were integral to the decisions to manufacture monogamous families and regulate maternal weaning times in order to do so (Hunt 1988).

Most official histories of epidemics read as plots of catastrophe and death, scientific discovery of a cure, recovery and control. So it was for sleeping sickness in the Congo (Lyons 1992). Yet STDs became endemic in colonial Zaire, and no neat narrative ever emerged. Syphilis and yaws were once easily confused, though Belgian colonial doctors seem to have distinguished them increasingly well from the 1930s. Yet social difference in *who* was protected from STDs remains a continuing theme. Miners and their wives were privileged patients. So, too, were soldiers. Once penicillin became available from 1950, STD rates went down as massive mobile campaigns became the Belgian colonial way (Romaniuk 1963; Vellut 1987). But even this was more of a short-term fringe benefit than a specific, targeted intervention; moreover, penicillin-resistant gonorrhoea soon set in.

¹ Not without a furor, mind you. There were heated discussions in the Conseil Colonial in 1923 about articles of the law with implications for European privacy. One article, seeking to impose medical visits on "any suspected persons due to cohabitation with a contaminated person", created an uproar for its "draconian" and "inquisitorial character" unknown in "any civilized nation" and in this case proposed as "applicable to whites as well as blacks staying in the Colony." There was also an insistence that medical treatment for venereal disease be made free, as was recommended by the *Ligue belge pour combattre le péril vénérien* (Conseil Colonial 1923: 68-73, 107-10, 121-29, 153-56).

‘A dying people’

Syphilis and gonorrhoea rarely killed, and only certain ethnicities received concentrated attention concerning their impact on fertility. So it was among the Nkundo (Mongo) of the central basin of Zaire’s equatorial forest, notorious from the 1930s for their falling birth rate. I could probably fill two filing cabinets with colonial documents on the population problem among the Mongo in the central basin of Zaire’s equatorial forest. Demographers, doctors, gynecologists, social workers, missionaries, officials, and private planters —all literate Europeans— descended here into this land of ‘a dying people,’ joining what became a veritable industry of colonial research focused on why Nkundo women were not becoming pregnant and bearing children. The region became one of the most important sites for what by the post-World War II period was a major subfield of medical practice in Belgian Africa, colonial gynecology.¹ And its population probably underwent the most intense, systematic gynecological investigation of any geographic area of the colony. The Coquilhatville hospital was operating an anti-venerean clinic by 1925 (RBCB, 1925: 12), and Dr Rebuffat (1927) soon began studying the relationship between syphilis and miscarriages in this city. By the late 1930s, there were reports that one of four persons in the region had gonorrhoea. By the 1950s, all endemic diseases but gonorrhoea had declined (De Thier 1956: 135-36), and one of the only infertility clinics in the colony was operating in Befale (Allard 1955).

Nor was it only Flemish missionaries, private Belgian planters, and colonial officials and doctors who were noticing there was a problem (Hunt 1993). In 1935, many Nkundo joined to form a fertility cult called *likili* in this plantation district of the Belgian Congo. The cult’s ‘slogan,’ according to an observing Belgian planter, was: “Let us give birth like before the whites” (Lodewijckx 1948). *Likili* healers told cult members that people were using umbilical cords in medicines to make others ill and that the use of imported colonial commodities were endangering fertility. They also advised that exposure of a woman’s genitalia prevented the bearing of children. Some Europeans embraced a memory of *likili* as a sinister, xenophobic ‘secret society’ that became ‘a public danger’ (Lodewijckx 1948). The *likili* organizers prohibited the use of all imported objects, and encouraged people to gather for large, festive, nocturnal ceremonies where they burned all their beds, mattresses, blankets, mosquito nets, and imported clothes. New medicines spread with *likili* as these old charms —the signs of colonial modernity— went up in flame, until one day ‘the White Man from the State came’ to round up and jail *likili* followers. A refusal by *likili* women to undergo colonial gynecological exams —‘because they did not want to take their clothes off in front of the doctor’— provoked a clash with the authorities. State authorities, deeming *likili* a xenophobic, public danger, vigorously suppressed it as a dangerous ‘secret society’ (Ekonyo 1939), and this in an era when official

¹ Second probably only to Leopoldville (Hunt, forthcoming).

memory was still fresh with terrifying images of the healing prophet Simon Kimbangu rising up in the lower Congo and leading crowds of his afflicted followers away from hospitals and tax-paying as they sang anti-colonial, apocalyptic hymns (Andersson 1958).

There were intense conflicts in interpretation about the causes of Nkundo infertility, not only between *likili* members and colonial doctors, but among Europeans. Indeed, these moral conflicts erupted as far off as Bangui in the late 1950s when Anne Retel-Laurentin sat down for her colonial dinner in the late 1950s. AEF (Afrique Equatoriale Française) officials asked her about ‘serious’ Belgian research on Nkundo abortifacients. She scoffed at what she called ‘the thesis of voluntarily sterile women’ and wondered aloud if Gustav Hulstaert, a Flemish priest and key writer on Mongo infertility, knew ‘how people make children’ (Retel-Laurentin 1978: 121). Flemish missionaries were not the only ones involved in the Mongo region. Mobile, medical census work in most parts of the Belgian Congo could resemble army operations by the 1930s; doctors arrived with soldiers and those who did not comply went to jail. The result in terms of consciousness among the average Congolese subject was a loathing of biomedicine as ubiquitous *mutumbula* fantasy tales (Ceysens 1975; Hunt, forthcoming). The context of *likili*, therefore, was one of intense gynecological, venereal investigation under the same armed conditions. When *likili* leaders insisted that such bodily exposure was polluting and *likili* women began refusing these biomedical intrusions in search of STDs, their refusals — in the face of the derivatives of their suffering — landed them in jail.

In 1941, a Nkundo Catholic by the name of Paul Ngoi published a poem in a mission magazine, *Le Coq qui chante*, about his people’s infertility woes. Like *likili*, the poem expressed the human pain that accompanied the social facts of colonialism in this part of equatorial Africa: “A European has a child, a Nkundo has sterility” (Ngoi in Hulstaert 1972: 101-03). Yet Ngoi’s poem also suggests a tortured, colonized consciousness, quite unlike the anti-colonial, anti-mimetic consciousness that underlay the commodity-burning sprees of *likili*. Paul Ngoi also blamed colonial mimesis, not Europeans or their objects. He stressed the ignorant, confused, faulty mimicry of his people; he blamed, quite literally, Nkundo stupidity.¹

These two examples of local interpretations of Nkundo infertility — *likili* of 1935 and Ngoi’s poem of 1941 — are less significant for their sequential than their class character.² Moreover, there was an

¹ Hulstaert’s (1972: 101-03) French translation of the Lomongo goes: “Lorsque nous vivions au commencement / Beaucoup de mères à nombreuse progéniture / Augmentaient fort le monde / La manière des blancs est arrivée / Avec des coutumes nombreuses / Nous, avec l’esprit d’imitation et la stupidité / La progéniture nombreuse s’éteint dans le pays / Le blanc a un enfant / Le Nkundo a la stérilité / C’est le noir imbécile qui est bête / Avec son esprit d’imitation irraisonnable.”

² My evidence here is slim; more research in the published writings of Congolese *évolués* and ethnographic historical field work in the Mongo region is needed (and planned). Yet I found a similar and much thicker contrast between the writings of

ambivalent simultaneity of explanations in *likili*, in the poem, as there are within interpretations of AIDS today. Attitudes and access to biomedical care, like the risks of getting seriously sick, remain class phenomena, as is demonstrated in stark differences in seroconversion and AIDS incidence among pregnant women with HIV and their offspring in two Kinshasa hospitals (one charged eight dollars, the other sixty for a delivery) (Ryder and Hassig 1988; Ryder 1989). Likewise, social and economic circumstances colour local representations of disease. It is from this vantage point of the multiplicity, instability, and social and economic variability of representations of and responses to STD-caused Mongo infertility that I want to broach all too slender evidence on representations of AIDS in Zaire — some global, some local, some urban, some rural, some ‘popular,’ some more of a post-colonial, client class of powerful Zairian ‘big men.’

AIDS representations and female categories

I found myself moving between awe and fury as I familiarized myself with the literature on AIDS in Africa and Zaire; awe at the stamina and dedication of people working to understand and prevent this disease that crosses sex with death, fury at some of the career-making, accusatory interventions into the suffering of the dying, the widowed, the orphaned, the contaminated. I appreciated those who attempted broad, social epidemiologies of AIDS in Zaire, who linked the difficulties of preventing AIDS to the evils of structural adjustment, economic crisis, and poverty (Schoepf 1988), who dreamed of empowering women (Schoepf 1993; Baylies and Bujra 1995) and, as Christine Obbo (1993) expressed it, making ‘men the solution’. I found inspiration from stories of youth seeking change and condoms and conversations about sex (Obbo 1993; Setel 1992). But when I stumbled upon articles speaking of prostitution, promiscuous sexuality (Irwin 1991; Bertrand 1991), and ‘dry and tight’ sexual practices (Brown, Okako, Brown 1993; Vincke 1991), the marks of a prurient sexual fascination combined with an implicit moral condemnation of the afflicted and poor brought me back to rage at the derivatives of this affliction in Africa.

I learned that factory workers were rounded up for focus group discussions in Kinshasa by taxi, for example, and fed ‘a hot meal’ before they were delivered back out of sight, their voices transcribed and translated twice, once out of Lingala into French, and once out of French into American English, so some internationally funded

Congolese Protestant evangelical nursing men of Upper Zaire and *tokwakwa* tales ubiquitous in the region about the meanings and purposes of medical technology, biomedical surgery, and colonial objects of mobility (bicycles and automobiles) in the 1930s, the decade when colonial medicine and mobility intersected with greatest novelty. I argue that it is important to not imagine either category of representation as class-bound, even if the nursing men’s writings (like Ngoi’s poem) were class- and church-based in provenance and orientation. Every local Congolese knew *tokwakwa* variants, and published church magazines likely took on oral forms of circulation once they were read aloud in villages (Hunt 1997; 1994).

contractee could feed their humble responses into a computer and point to differences between African men's and women's levels of ignorance. The point? To tell 'social marketers' and their client song-writers where they needed to work harder on correcting 'African misconceptions' about mosquitoes and condoms, sex and death. Meanwhile, out leaked a complex local vocabulary for categories of women —*ndumba*, *mvuanda*, *mingando*, *londonienne*— that emerged during these sessions, somewhere between the taxi rides and the hot meals, somewhere on tape. Yet no attempt was made to explain or comprehend who *uses* these names, what their historical sociologies are, nor how these women speak of themselves (Irwin 1991).

Several studies note the effect of a song by Franco Luambo, Zaire's famous popular musician, his 'Attention na Sida' (Auvert *et al.* 1990; Bertrand 1991). I do not know all I would like to know about how Franco composed this song, though there are enough references to its impact in research reports related to behavioral change, knowledge, and 'social marketing' to suggest that its composition and release has a history much more complicated than that of a powerful 'big man' superstar suffering from the knowledge that he was dying of AIDS (Ewens 1994). The stigmatization and forcible removal of 'prostitutes' from Kinshasa's 'main thoroughfare' (Auvert *et al.* 1990: 427) that seems to have accompanied Franco's brief words —'You gentlemen, *citoyens*. Beware of prostitutes'¹— remains, to the best of my knowledge, a suppressed history.

Another Kinshasa study also took up the subject of 'sex workers,' though it took up their lives and ailments rather than only handing out hot lunches. It did not assume that all women will always manage to use condoms, nor did it blame them when they did not. While providing education and encouragement about condoms, it also provided free STD treatment services. It proved that it is possible to diminish seroprevalence conversion rates for sexually active women, whether they were faithful condom users or not. Not to the same degree, of course, but in a 'nonjudgemental' way to the 'vulnerable' population of 'sex workers.' Yet not only these women were vulnerable. The project was vulnerable as were all the foreign-funded, research derivatives operating in Kinshasa. There was major civil unrest and looting in Kinshasa in 1991, and this women's center was one of the many international AIDS projects (Projet Sida, Connaissida, etc.) that suddenly disappeared from the country (Garrett 1994; Schoepf 1995; Laga *et al.* 1994). Civil strife and political repression, like structural inequalities and poverty, tend not to fit into most epidemiological interpretations of AIDS. Yet, like Retel-Laurentin's colonial dinner in Bangui, these derivatives —and their sudden evaporations— are an integral part of the social field that we work within and must study.

¹ Franco's word choice here —*ndumba*?— needs verification with the original Lingala; I have thus far only been able to consult an English translation of the song (Ewens 1994).

I still wonder about these so-called 'sex workers' and what has happened to them since this center closed its doors. The term 'sex worker' may be a felicitous euphemism. It does not contain the immoral connotations of prostitute as it combines the realities of many women's lives: the economics of providing sexual, affective, and domestic services to men (White 1990). Does this term mean money for sex? Street-walking? A combination of cooking, sexual, emotional services for men who help a woman get by and perhaps hold them in their arms and make them laugh from time to time, too? There are enough good ethnographies and histories of prostitution in Africa to suggest that these are important questions (e.g., La Fontaine 1974; White 1990). Yet, to the best of my knowledge, no one has taken on an ethnography of prostitution in Kinshasa since Jean La Fontaine (1974). What has happened to the social categories and aspirations that she identified in the 1960s? How telling was popular music of Kinshasa's Pepsi generation of the 1970s, when Mavatiku's 'Ozone' sang about the cries of a mother watching her school girl daughter going to the market to borrow clothes from *femmes libres*? Her daughter explained: '*Mama ezali la mode*' or 'Mama, it's the style' (Bemba 1984: 151).

Social names for women never have been and never will be stable, and we need to work against facile glossing of social categories for women in our own representations of AIDS. 'Sex worker' may be less judgemental than prostitute, but I still want to know about *ndumba*, *mvuanda*, *mingando*, *londonienne*, and *deuxième bureau* as locally understood categories and locally used names for women. Are these social categories of women equally at risk for AIDS? How is their risk perceived by others and by themselves? What is the history of the formation and reformation of these categories? and how is it tied to the history of STDs, sexuality, and forms of state power in the colonial and post-colonial periods? Congolese chiefs were known to requisition *ménagères* for white colonial men (Vermeersch 1914), and some have suggested that Mobutu's MPR party (Mouvement populaire de la Révolution) men used *animation*, political spectacles of dancing young women, to requisition sexual 'prey' (Tshibanda 1986: 68). Colonial mother/whore dichotomies never fit local social realities, and they certainly do not now. Indeed, only one kind of mother truly counted in Belgian Africa, women (black or white) who were monogamously married to salaried employees and skilled wage workers. Urban single women were labelled and taxed under the thinly veiled term *femmes vivant théoriquement seules*, and those suspected of being prostitutes were subject to medical inspections and hospital incarceration. 'Whore' took on a huge semantic range in this context, taking in everything from polygynous wife to single woman, prostitute to slave. Nor were these only discursive impositions. They became moral categories of taxation and urban residence legal codes, and Congolese men and women invented new local, camouflaged categories —like *supplémentaires*, the colonial antecedent to *deuxièmes bureaux*— as they negotiated and manipulated their implications (Hunt 1991).

I want to know more about the post-colonial histories, too, about their names and their uses, about how they are being reformed and deformed under the circumstances of AIDS and its derivatives. How are local names for 'sex workers' related to maternity and fertility, clothing and appearance, class, commerce, and travel abroad? How are 'sex work' and the *deuxième bureau* category shifting as the economic and political crisis in Zaire deepens, a middle class seems ready to disappear (Yoka 1996), and new gangster-like masculinities are formed by urban youngsters ready for any bodily risk as they come and go from diamond digging in Angola (De Boeck 1996)?

These questions are not meant to belittle this modest, brief, carefully worded report about what was, as best as I can make out, a genuinely helpful, carefully designed, and unpretentious effort to assist women vulnerable to AIDS, by providing STDs screening and treatment and withholding moral judgement (Laga 1994). There have been continuities and repetitions in stigmatization with the arrival of diverse consciousnesses of AIDS in Zaire. A Catholic discourse blaming everything but celibacy or monogamy has been prominent (*Le Sida* 1987). Didactic booklets on AIDS, created for Zairian readers in the late 1980s, however, were constructed not around sexual shame, but around the local popular expression that SIDA's acronym stood for an imaginary syndrome to discourage lovers; people must instead face the truth (Dibandala and Courtejoie, n.d.). The same logic clearly has structured much action-oriented and attitude-collecting research in Kinshasa.

Moralities of shame and mockery

How harmful would judgements be? Evidence from the colonial record is marvelously contradictory. Hygiene manuals were explicit when they referred to venereal diseases as 'sicknesses of shame.' So they were for European men and women, in Europe and the colonies. What did Congolese do with stigmatizing labels? The evidence suggests not very much. It wasn't with Congolese that there were problems with the sick hiding venereal disease and denying medical fact (Barthélémi 1921). Rather, colonial doctors spoke about how Congolese men would show up spontaneously, unbothered about the sexual provenance of their symptoms and seeking shots, sometimes coming in before they had symptoms to protect themselves from the potentialities of their sexual activities (RBCB 1925, 1929). These references were though, as best as I can figure it so far, Congolese men not women. Congolese women were dealing with shame — big time — due to the sequelæ of gonorrhœa and syphilis.

Why were women struggling with infertility? Because men were carrying it home from industrial and commercial work sites to rural areas where women and children were left behind (e.g., RBCB 1929: 28). Perhaps because they were intensifying gynecological ritual and cleansing under these conditions in an attempt to be healed, thereby further exposing themselves to pelvic inflammatory disease (Hunt

1993). Those in the Congo who were most protected were the wives of skilled workers in mining camps, where there were intensive social hygiene campaigns. The women who suffered the most, however, were those where there was less access to health services and more male migration. African women were much less likely to be patients of biomedical services in colonial Africa than men. In Coquilhatville, where colonial gynecology began so early and intensified so dramatically, this gender disparity was also the case. Yet women were a large percentage of doctors' surgery patients; indeed, most surgery patients *were* women in this city in the 1920s and most of this surgery was gynecological (Hunt, forthcoming). The evidence suggests that even though women generally avoided colonial medicine (Lyons 1992) and feared surgery as disembowelment (Hunt, forthcoming), in areas where infertility was high, women lay their bodies down in hope that colonial surgeons' salpingitis investigations would heal their shameful afflictions.

There is a lesson here for those who work with relationships among female sterility and HIV vulnerability. All of us who work on AIDS in Africa, including perinatal transmission of HIV, risk making "split references to the sufferer as both a victim and the one responsible for her own fate" and thus "act as shears through which suffering" —motherhood and infant mortality— "is sought to be cut off from the victim to become the child of the pronouncer of this discourse" (Das 1994: 141, 162). Consider again a line from Franco's song: "Ladies, avoid getting pregnant If you know you have the virus. It is bad to ignore this, as your child could die young". Indeed, these moralizing words suggest that Franco's suffering was being cut off from him, that others wrote these largely didactic lyrics for this client of international funds.

I am speculating here, though consider what gigantic symbolic capital Franco must have represented in Kinshasa's social marketing campaigns, if international funders understood that his body was dying of AIDS. Global forces may have held his words hostage, but they could not control the meaning of his music nor that of his death. It is not possible to know how Franco is presumed to have died and not take in the lyrics with compassion for his suffering and respect for his wisdom:

"Those who used to eat and drink with me
Have started to ignore me
They say I have got the AIDS sickness
All my friends are cutting me off...
AIDS has made us forget all other illnesses
If a person is sick, they say it is AIDS
If a person has fever, they say it is AIDS
If a person dies, they say it is AIDS
But why do we forget the other illnesses?
Oh God, Oh God, Oh God".

Franco gave specific advice to many people in his song: youth, doctors, governments of rich countries, teachers, professors, and

mothers. And he made veiled references to condoms for all: "Protect your own body, I'll protect mine. The best way to avoid death is to protect yourself." He spoke to priests, pastors, rabbis, and imams with these words:

"Use your office to help
 Preach what society must know about AIDS
 Do not hold back. It is your duty to tell the people that
 AIDS is a punishment from God; it resembles
 Sodom and Gomorrah in ancient times
 Use your prayers to ask God the way to salvation
 All my family have run away from me
 Because I have AIDS. I am left with only my mother,
 Who has to suffer again all the sickness of my childhood"
 (Ewens 1994: 266-69).

Franco's lyrics contained a complicated moral discourse, towing the line perhaps for international aid funders, but evoking no more frightening and condemnatory of God than the Old Testament's of Genesis 19. The same references to Sodom and Gomorrah and divine punishment are common in popular opinions collected in diverse parts of Zaire (Mbu 1995: 11-12; Tayaya 1995: 23; Basuakuamba 1995; Wayikanga 1995; Wendo 1995), where they circulate alongside ideas of sorcery, envy, and unjust 'human agency' (Farmer 1992). The range of popular opinion is wide and creolized in this data collected by five Zairians among Sakata, Humbu, Hungana, Mbala, Ngongo, Yansi, Lulua, and Tetela men and women.¹ Sida is a form of biological warfare created by American scientists. It is an imaginary disease invented by corrupt doctors who go after women in bars. Sida is caused by human sorcerers and angry natural and ancestral spirits. It is the work of Satan. It is an imported sickness created in the laboratories of white men. Sida is a new manifestation of an incurable, ancient deadly diarrhea provoked either by a particular spirit that lives in anthills and attacks thieves; poisonous mushrooms which snakes eat to intensify their venom; or by other particular bitter foods, types of yams, fruits, meats, or caterpillars. Sida is a disease of someone who had good luck and became rich, just as it is a consequence of adultery, theft and injustice. Married women jealous of their husbands combined with doctors to invent the disease to keep their husbands from practicing adultery. Old people say that sida is punishment for the acceptance of the colonial occupation of Zaire by Europeans and continuing mimicry of their ways. Others blame white tourists who have travelled through sleeping with Zairian girls. Funeral rituals exist to capture back the wealth of the person who has died from AIDS, and since Franco died people are afraid that saying or singing the word sida may 'entrap' them with the disease.²

¹ And quite distinct from that collected under a \$10,000 dollar KABP (knowledge, attitudes, beliefs, practices) study; see Irwin 1991.

² These opinions come from the five studies collected in one volume, most which read as a series of accounts of what particular men and women said; several opinions recur

I cannot do justice to this fascinating moral commentary on disease, wealth, risk, jealousy, and misfortune here, not without the sustained kind of ethnographic research for which it cries. It is important to take account, however, of the severity of the social and economic crisis in Congo-Zaire in this post-*pillages* period, with extraordinary dollarization and hyperinflation, where overloaded, diamond-smuggling planes crash into city markets and dead bodies pile up in morgues. The increasing 'apartheid' in wealth and justice, as Yoka Lye has expressed it, is associated with 'malediction.' SIDA and Ebola remain, he has said, "terrible signs of divine punishment against unrepentant initiates of artificial paradises which suspect windfalls [of dollars] seek to conquer in vain" (Yoka 1996).

Bogumil Jewsiewicki (1995), in a biography of Chéri Samba points to this now world-acclaimed Kinshasa painter's ambivalence about multiple wives and extra-marital sex. Chéri Samba has created two paintings, one where he is being hung by his exclusive contract with a Parisian gallery owner, the other of a man committing suicide because people say he has AIDS. Further, the first time that Chéri Samba did not keep to his conviction that he should always show a painting in Kinshasa before exhibiting it abroad was with his painting 'Les capotes usagées.' It is a vision of Prudence condoms, introduced on a massive scale in Kinshasa by USAID social marketers in the late 1980s. The condoms are being thrown out from a Hotel Prudence's bedroom windows by unseen lovers, while children play with this detritus of AIDS prevention work as newly found toy balloons. This ambiguous, half-mocking, half-condemnatory commentary about changing material culture, sexual habits, and city children in Kinshasa's popular neighborhoods was somehow not appropriate or not intended for a Kinshasa audience. This painting that carried such cachet in New York and Paris would have had a different social meaning in Kinshasa besides. Local Kinshasa understand that this is a city where '*bafonctionnaires*' too 'become so thin' (Kinshasa street vendor's 1995 song in De Boeck 1996) while a few hundred families grow more and more wealthy. Local people understand that this is a country where people will no longer risk voicing the word SIDA, this ensnaring disease of bad luck (Mbu 1995) that is experienced as a punishment for obscene wealth besides cruel poverty. Local people interpret AIDS as an affliction that is not transmitted but 'caught' by the rich and those unfortunate others who, entrapped by the malediction of their greed, join them in shitting themselves to death (Tayaya 1995; Colebunders *et al.* 1988).

It is a strange, excremental world we live in, Chéri Samba's paintings suggest, where local people's lives, sufferings, and conflicts get ricocheted in and out of postmodern Africanisms of a savage, dark continent associated with slavery and sexuality, debt and condoms, disease and libido, where people are held hostage by international contracts and global and local injustices. Meanwhile children and

in the various text. See Mbu 1995; Tayaya 1995; Basuakuamba 1995; Wayikanga 1995; and Wendo 1995.

painters frolic with new toys, these reified imported objects called Prudence, expressing laughter and disdain at the seeming futility of HIV prophylaxis for those who will die poor in a lopsided world.

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Nancy Rose HUNT, *STDs, suffering, and their derivatives in Congo-Zaire: notes towards an historical ethnography of disease*

Summary — This paper provide an historical review of STDs in Congo-Zaire, with particular attention paid to how Congolese subjects experienced and interpreted STDs and their treatment in the colonial period, and to how they experience and interpret AIDS and AIDS interventions today. Prior to World War I, colonial hygiene focused on venereal disease and promiscuity among European men; from the 1920s, social investments in the health of Congolese workers and their families began. The impact of syphilis and gonorrhea on subfertility became a key issue of colonial research among the Nkundo (Mongo), where local fertility concerns were also manifested in a quickly suppressed 1935 local religious movement called *likili*. This history is used to critique the derivatives of AIDS in Kinshasa, that is, recent AIDS research and programming, and grasp the integrity of popular representations of AIDS as discerning, parodic, social epidemiologies of wealth and affliction in Mobutu's Zaire.

Keywords: Kinshasa • Congo-Zaire • colonial hygiene • *nkundo* • infertility, female categories • syphilis • gonorrhea • history • popular culture.

Nancy Rose HUNT, *Les MST, la souffrance et leurs dérivatifs au Congo-Zaïre : notes pour une ethnographie historique de la maladie*

Résumé — Cette présentation est une étude historique sur les MST au Congo-Zaïre, avec une attention particulière à la manière dont les Congolais ont perçu et interprété les MST et leur traitement durant la période coloniale, et comment ils expérimentent et interprètent de nos jours le sida et les activités de lutte contre le sida. Avant la première guerre mondiale, les autorités coloniales ont mis l'accent sur les maladies vénériennes et la promiscuité des hommes européens ; à partir des années 1920, débutent les investissements sociaux en matière de santé pour les ouvriers congolais et leurs familles. L'impact négatif de la syphilis et de la gonorrhée sur la fécondité est devenu pour les colons un problème majeur de recherche auprès des Nkundo (Mongo), où les préoccupations locales en matière de fécondité se traduisent en 1935 par un mouvement religieux local, appelé *likili*, qui a été très vite réprimé. Cette histoire sert de fondement pour une critique des dérivatifs du sida à Kinshasa que constituent la recherche et la planification en matière de sida. Elle capture l'intégrité des représentations populaires du sida comme des épidémiologies parodiques et sociales de la richesse et de l'affliction dans le Zaïre de Mobutu.

Mots-clés : Kinshasa • Congo-Zaïre • hygiène coloniale • *nkundo* • stérilité, catégories féminines • syphilis • gonorrhée • histoire • culture populaire.