Treating Diabetes in Cameroon: A Comparative Study in Medical Anthropology

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Abstract

This thesis presents and analyses the findings of research into the management of diabetes in one urban and one rural district of Cameroon. The phenomenon of non-communicable diseases like diabetes mellitus is becoming a recurrent problem in middle and low-income countries, notably in Sub-Sahara Africa. This ethnographic study, in the tradition of medical anthropology, involved over two years of fieldwork, and has been undertaken to shed more light on the paradoxes that underpin the interpretation and management of diabetes in Cameroon. Initially, I set out to study how diabetes was managed in clinical settings; but as the research developed my enquiries led out from the clinic to encompass first the perspectives of patients and their families, and in the end the perspectives of traditional healers also. It thus draws together four distinct sets of actors engaged in the process of treating diabetes mellitus: clinical staff, patients, their families, and traditional healers. In this research, I explored the ways in which Cameroonians negotiate a meaningful and manageable path between alternative therapeutic regimes. But as my analysis shows, behind different therapeutic approaches lie alternative presumptions about aetiology and efficacy, about behaviour and the body.

In integrating the perspectives of the different actors identified above, the research highlights three major themes. The first concerns the concept of 'compliance', and the language of frustration voiced by clinic staff about patient reluctance to adhere to medication and advice. The second concerns 'aetiology' and the ultimately incompatible styles of reasoning and understanding advanced to explain the causes and consequences of diabetes, including its complications and its significance as chronic and incurable in a

cultural context where the notion of an incurable disease is still seen as unconvincing. The third concerns ideas of 'power', and the differing ways in which power is attributed or assumed, ranging from the apparent power of biomedical knowledge and clinic injunctions, to the assumed power of traditional explanatory frameworks, or the powers of divination of traditional healers, or the powers of witchcraft or ancestors in inducing diabetes.

My thesis is unusual (a) in subject matter, (b) in its comparative scope, and (c) in being done by a Cameroonian ethnographer. While rural Bafut has been the site of several previous ethnographic studies, almost nothing has been done ethnographically in Yaounde. This thesis shows that, contrary to my initial working hypothesis, the similarities in outlook and behaviour between rural and urban settings are more striking than the differences. The universe of the clinic and biomedicine is not more effective and accepted in the city, as might have been anticipated, for in both settings traditional healing beliefs continue to hold a strong influence, creating the problems around 'compliance' mentioned above.

Dedication

I dedicate this thesis to my family: my mother (Futeh Kai Awah), my wife (Ana Nkouetcha Awah), my kids (Kaïseuh, Awah Jr, Ikaititchia and Ngando), my brother (Awah Mbeh Azibou) and sisters (Mrs Rebecca Ihims, Mrs Ateh Evelyn, Ms Margaret Awah, Ms Magdalene Awah).

Declaration

I confirm that this is my own work and the use of all material from other sources has been fully and properly acknowledged.

Paschal Kum Awah

Abbreviations

AIDS:	Acquired Immuned Deficiency Syndrome
ANSA:	Action on Non-communicable diseases in Sub-Sahara Africa.
BP:	Blood Pressure
CHC:	Catholic Health Centre
CHU:	Centre Hospitaliere Universitaire (University Hospital Centre)
DFID:	Department For International Development
DH:	District Hospital
DM:	Diabetes Mellitus
DMO:	District Medical Officer
DO:	Divisional Officer
EBHC:	Etoug Ebe Baptist Health Centre
Ed:	Editor
Ed(s):	Editor(s)
ENHIP:	Essential Non-communicable Diseases Health Intervention Project
EPC:	Eglise Presbyterienne Camerouniase
EPCH:	Eglise Presbyterienne du Cameroun, Hopital de Djoungolo Annexe de Biyem Assi
FGD:	Focus Group Discussions
HIV:	Human Immuno-deficiency Syndrome
Hrs:	Hours
HT:	Hypertension
IDI:	In-depth interviews

IEC:	Information, Education and Communication
KI:	Key Informants
MOH:	Ministry of Health
NCD:	Non-communicable diseases
NGO:	Non-governmental organisation
PHC:	Presbyterian Health Centre
RAP:	Rapid Assessment Procedure
SSA:	Sub-Sahara Africa
WHO:	World Health Organisation

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A note on orthography

The orthography of Bafut that I have used in this thesis derives from the alphabet adopted by the Cameroon government for the transliteration of Cameroonian Languages and the preparation of reading materials after a meeting of authors in March 1979. I have made use of a word list from a document purchased from Dr Joseph Fonyam of the University of Yaounde I, and of *A guide to Bafut Orthography*, by Joseph Fonyam.

In the text I use the elided form of words. Bafut is a tonal language and although tones are important in Bafut speech, I only indicate them where a difference in tone changes the meaning of the word. I also use Pidgin English words, which are English Language words that carry different meaning from that used when it is English Language. Some French Language words have been used and their meanings in English Language explained. A glossary of terms has been attached as an appendix.

In the text I have used square brackets [] to insert synonyms of English words to explain Bafut, French and Pidgin English languages words (written in italics) used in this thesis. Square brackets have also been used to emphasize certain points. Round () brackets have been used to enclose cited authors and to lay some emphasis about a word or phrase.

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Chapter I

Introduction

1.1 Introduction

This is an ethnographic study, in the tradition of medical anthropology, of the management of diabetes in Cameroon. It is based on fieldwork conducted over a period of more than 2 years (from June 2001 to June 2003) in a health district of the capital Yaounde, named Biyem-Assi, and in a rural part of Anglophone North-West Cameroon, Bafut. The phenomenon of non-communicable diseases like diabetes mellitus is becoming a recurrent problem in middle and low-income countries notably in sub-Sahara Africa (Mohan and Alberti 1997, Alberti 2001, IDF 1998, WHO 2005, Mbanya 2004). A decade ago diabetes was considered a problem of the developed world and of the well-to-do but changes in African standards of living due to rapid urbanisation; and changes in modes of life have triggered its occurrence in both urban and rural communities. Like several other non-communicable diseases now emerging as significant public health issues in developing countries like Cameroon, diabetes has not until recently figured in local consciousness and awareness, nor has the disease and its symptoms registered much with traditional healers. The current situation of diabetes in Cameroon and the known epidemiological status necessitates the search for the cultural aspects that underpin it, so that an in-depth appraisal can be made of the different issues that surround its management.

Before I set out to conduct fieldwork in 2001, a series of projects had been carried out in Cameroon with funding from the European Union, Department For International

Development (DFID)[1] and World Health Organisation (WHO)[2] under the brand names of ENHIP[3], NCD[4] Poverty and ANSA[5] Projects. They provided the necessary ingredients for drafting this study. Each of them highlighted the epidemiology of diabetes and the quality of biomedical care provided to patients. One thing that caught my attention, from these studies, was that the family was a key actor in the diabetes management process. My brief interactions with staff and patients in health units in Yaounde echoed one particular message from clinic staff: that diabetes patients were not complying with treatment. I asked myself why this was so and if that obtained in both urban and rural areas? Then I concluded that it was worth exploring the health beliefs and treatment seeking patterns about diabetes care to know if there was really a problem of compliance and how far this stretched. I decided to restrict myself to studying type 2 diabetes patients. This meant that my participants in the study were to be adults. I then set out to conduct an ethnographic study of the management of type 2 diabetes in Cameroon. It is comparative, based on anthropological fieldwork in an urban and a rural setting [Biyem-Assi - Yaounde and Bafut].

This chapter focuses on the topic of the thesis. The chapter is divided into five sections: an introduction (1.1), the aims, objectives and research questions of the study (1.2); the problem of diabetes in Cameroon (1.3), the summary of main themes (1.4) and the outline of the thesis (1.5).

[1] DFID: Department For International Development
[2] WHO: World Health Organisation
[3] ENHIP: Essential Non-communicable diseases Health Intervention Project.
[4] NCD: Non-communicable diseases.

1.2 Aims and research questions

This section presents the aims, objectives, and research questions of the study. The purpose details the rationale for which the study was conducted. Anthropologists always end up modifying or changing the original aims, objectives, purposes and research questions that they initially set out to investigate. Therefore, those presented here are the end product of these changes.

Aims

The first aim of this study was to elicit health beliefs about the causes, experiences, and management of diabetes type II; pointing out areas where the illness beliefs of lay people and the medical knowledge of clinicians may lead to misunderstandings and affect effective modern treatment. The second aim was to explore the ways in which Cameroonians negotiate a meaningful and manageable path between alternative therapeutic regimes, behind which lie alternative presumptions about the etiology of ill-health and well-being.

Objectives

Therefore I decided: firstly, to identify, compare and contrast beliefs about diabetes and its management between the urban and rural health districts of Cameroon. Secondly, I set out to establish the role that clinic staff, patients, family members of diabetes patients and traditional healers play in the management of diabetes; and thirdly, to analyse the power relationship between clinic staff and patients; and between patients, families and ancestors.

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[5] ANSA: Action on non-communicable diseases in Sub-Sahara Africa.

The initial purpose was to explore health beliefs and the role of the family in the management of type 2 diabetes contrasting between two health districts of Cameroon. But the purpose spread out to actors other than those of the clinic and the family. This provided in-depth evidence to address the issue of compliance and other themes that emerged as fieldwork evolved. This, I thought was going to illuminate possible patterns of and rationales for resource use in a plural medical system.

It is widely known that the beliefs about and the asymptomatic nature of diabetes, make it difficult for people to consult a medical doctor at its early stage (Gill 1997). Furthermore the disease necessitates treatment for life, which people in Cameroon can hardly afford (Mbanya 1997). According to the ANSA study (Mbanya and Awah 2000 -unpublished) only 30% of diabetes patients who were regularly followed up in clinics were aware of diabetes as being chronic. Then I questioned if this could be the source of the issue of compliance. The enquiry about issues surrounding compliance has led this study to explore ways that can subsequently provide models to target the care and prevention of diabetes.

To understand the subject matter of this study, it is worthwhile knowing the biomedical meaning of diabetes, as defined by IDF (2001), the main advocate of diabetes care.

Diabetes mellitus is a chronic disease, which has been described as a state of raised blood glucose (hyperglycaemia)[6] *associated with premature mortality* (IDF 2001). This definition sheds light on the meaning of diabetes as defined by the health practitioner and as it was articulated in the diabetes clinics. The ethnographic chapters of this book will provide the meaning of diabetes from the laypersons' perspective. These meanings will help in understanding the rationale behind the different choices and decisions made by patients and their families and the interactions that they have with clinic staff and traditional healers. Just as diabetes in the biomedical sense has its classification[7], I shall explore the lay classification in the ethnographic chapters.

Biomedical experts have been changing the classifications, methods of diagnosis[8] and treatment of diabetes over the years. But certain lifestyles with a degree of risk factors are said to be responsible for the development of diabetes type 2. It has been illustrated that race, family history, age and sex are non-modifiable risk factors (IDF 1997, Mohan and Alberti 1997, Alberti 2001, WHO 2005). The dramatic rise in the prevalence of diabetes

[6] Diabetes arises when the beta cells in the pancreas fail to produce enough of the hormone insulin, or when the body cannot effectively use the insulin produced. Failure of insulin secretion, action or both leads to raised blood glucose and other metabolic changes, which if uncontrolled, can cause serious complications. The most important of these are retinopathy (affecting the eyes), nephropathy (affecting the kidneys), neuropathy (affecting the nerves) and cardiovascular disease (affecting the circulatory system) (IDF 2001).

[7] Most recently, a World Health Organisation (WHO) Consultation and American Diabetes Association (ADA) Expert Committee have divided diabetes into four main types. Type 1: Insulin required for survival due to lack of insulin produced by the body as a result of beta cell destruction. Type 2 is characterised by disorders of both insulin action and secretion, either of which may predominate, but both of which are usually present. Type 2 is controlled by diet, exercise and oral hypoglycaemic agents. Insulin may be required for metabolic control. Type 3 and 4 are those where the cause is known (e.g. genetic defects in beta cell function or insulin action, diseases of the pancreas, certain other hormonal disorders, or drug induced disorders) and that appearing for the first time in pregnancy called gestational diabetes.

[8] In a majority of affected individuals the diagnosis of diabetes is straightforward. If someone has typical symptoms of diabetes and a clearly raised plasma glucose level, the diagnosis is diabetes. Another clear diagnosis is one where a person has ketones in the urine and high glucose. A person without symptoms needs two abnormal results on separate occasions to be considered as diabetic. They have cut-off points for the glucose levels and associate them to complications that a patient may develop.

is closely associated with a lack of physical activity, obesity and a change to 'Western' style diets (Unwin et al 2001, Sobngwi et al 2002, WHO 2005). These changes, together with urbanisation and mechanisation, appear to be inevitable accompaniments of modernisation (IDF 1997, Mbanya 1998, Unwin 2001, Sobngwi et al 2002, WHO 2005). The classification, diagnostic criteria, risk factors and treatment for diabetes is the package that the clinic setting offers. These situate diabetes in the clinical context from which the study begins. A detailed analysis about lay understanding, construction and interpretation of diabetes will be given in the ethnographic chapters positioning it as an illness in medical anthropology terms.

But what is illness and what is disease? In the study, illness refers to the state of disorder as subjectively perceived and explained by lay people. Disease refers to medically defined pathology or biological processes (Good 1994, Helman 2001). In the Cameroon setting in which this research took place, 'illnesses' are locally defined and experienced; and 'diseases' as understood by clinicians may not correspond to these directly. This study has illuminated some general aspects about public knowledge, perceptions and experiences.

Why does the study take a comparative anthropological approach? The most appropriate way to provide sufficient evidence was to use an approach that warranted my being in the field and interacting with actors in the two settings. This led to the use of participant observation, whose procedure as applied in the fieldwork is explained in Chapter 3. I have taken a comparative anthropological perspective and approach in the study as a

means of achieving an in-depth understanding about diabetes as it is experienced, treated and managed in Cameroon. I see this work as my own contribution to providing anthropological data on diabetes; that can facilitate understanding about it and its impact on the health and chronic illness landscape of Cameroon. The rationale for doing this has been to provide local information that could be used in programming, designing and implementing policy specifically designed for Cameroon, without which Cameroon will continue to depend on foreign values in policy making. Experience has shown the failure of programmes to tackle certain communicable diseases that never considered local cultural values and beliefs in their design. As an original piece of work, I consider that if the diabetes programmes in Cameroon were to use these results it could make a difference to the effectiveness of its programme that may be worthy of emulation elsewhere in Sub-Sahara Africa.

Recent efforts have been made to study the incidence, prevalence and the risk factors of diabetes in Cameroon. Most epidemiological studies (IDF, 1998, Mbanya 1998, Mbanya 2004, Unwin et al 2001, WHO 2005) have concentrated in urban areas and others have been comparing the urban and rural areas, revealing the emergence of diabetes in both. This study has been done with a comparative focus between a rural and an urban setting, Bafut and Biyem-Assi respectively, to provide an overview and establish the relationship between them. These settings, by their location and ethnic composition, seem different from each other. But does this necessarily mean that the beliefs and approaches to illness in the two locations are different? This is one issue that I will be discussing in this ethnography.

Research questions

I set out to answer the following main questions. How do people perceive diabetes? Why do they perceive diabetes the way they do? How do people manage diabetes? What are the different support networks that people living with diabetes have or develop in the process of diabetes management? The ethnographic chapters will attempt answers to these questions and explore in depth the issues that have been outlined in the introduction.

1.3 The problem of diabetes in Cameroon

Cameroon, like other Sub-Saharan countries in Africa, has witnessed an increase in the burden of non-communicable diseases in the last decade. Formerly, communicable diseases, because of their high incidence, dominated public and policy makers' perception and treatment programmes. The tide started changing when cases of diabetes and its related risk factors were diagnosed and reported in the 1970s. However, diabetes had been largely void of any research before 1980. In 1980, Pisoh (1980) illustrated that diabetes and its related risk factors increased the burden of diseases in Cameroon. This was an indication of future danger; and the need for further research to shed more light on the prevalence, classification and aetiology of diabetes within African settings. However, a further decade elapsed before in-depth diabetes research was conducted.

The first major research done on diabetes was from December 1990 to July 1994, when 550 diabetes patients were prospectively studied at the Yaounde Central Hospital by Ducorps et al (1994). Their classification[9] of the patients, using WHO criteria, revealed that 24.7% and 73.7% were respectively type 1 and type 2.[10] The rest (1.6%) were classified as diabetes secondary to other diseases. Mbanya et al (1997) later confirmed the higher prevalence of type 2 (88%) diabetes over type 1 (12%) in a 1994 survey. The study further revealed the mean age of onset of diabetes to be 41 years and 49 years for men and women respectively, with a higher preponderance of men than women diagnosed. Being a hospital based study, the study of Ducorps was unable to describe the population prevalence of diabetes. A study conducted in 1994 in Yaoundé, using oral glucose tolerance testing, (Mbanya et al (1997) revealed age adjusted prevalence rates of impaired glucose tolerance of 5.8% and diabetes of 1.1%. Four years later (in 1998), another survey, this time using fasting glucose measurements, was conducted in the two sites of Bafut (a rural area near Bamenda) and Biyem-Assi (an urban area of Yaoundé) by Mbanya et al (1999) from which they revealed an age adjusted prevalence rate of diabetes of 5.5% in the urban area and 2% in the rural area.. The evolution of diabetes in Cameroon is a pointer to an epidemiological transition of diabetes and its risk factors. The transition is currently noticeable in Sub-Sahara Africa (Mahon and Alberti 1997, Mbanya 1998, Unwin et al 2001, Sobngwi et al 2002). It is an indicator that some changes in lifestyle have taken place within the past 25 years and will still do so, given the high prevalence of risk factors.

[9] What was previously known as insulin-dependent diabetes mellitus (IDDM) has become type I diabetes under this classification and non-insulin dependent diabetes mellitus (NIDDM) is now type 2 diabetes. Ducorps' classification was based on the old definition but I had to change to the new to keep with time.

From the Cameroon experience, it is evident that type 2 diabetes is already a major public health problem there as it is in the West and Central Africa region generally. Its impact in Sub-Sahara Africa is bound to continue; if nothing is done to curb the rising prevalence of risk factors for type 2 diabetes, particularly obesity and physical inactivity. A major problem that limits our understanding of the situation of diabetes in Cameroon and other African settings is the scarcity of studies undertaken to assess the cultural aspects of its management. This is made all the more difficult by the lack of standard recording systems to track newly diagnosed cases of diabetes.

1.4 Summary of main arguments

A three-way contrast is central to this thesis and provides the structure of its ethnographic chapters. These contrasts build around three perspectives: firstly, that of clinic staff in diabetes clinics of health centres or hospitals; secondly, that of diabetes patients and their family members; and thirdly that of people referred to as traditional healers. Two fundamental conflicts are revealed in exploring these perspectives: firstly, between patients and their family members (taken together) and clinic staff [health care workers], and secondly, between the two therapeutic traditions [modern and traditional medicines]. The ethnography will suggest that these conflicts are of similar magnitude in both urban

[10] Type 2 diabetes is what was formerly called non-insulin dependent diabetes mellitus (NIDDM) as opposed to insulin dependent diabetes mellitus now called type 1 diabetes.

[Biyem-Assi] and rural [Bafut] settings, but slightly different in the ways that people respond to them.

For the purpose of analysis, I have presented four ethnographic chapters following their order of emergence during my progress in the fieldwork. The ethnographic chapters start with an extended case study [Chapter V]. The following three chapters cover the perspectives of the clinic [Chapter VI], patient and family [Chapter VII] and perspectives of traditional medicine [Chapter VIII]. The themes that emerge from this thesis and which form the cornerstone of my analysis are compliance, aetiology and power. The research has revealed a very complex relationship among the actors revolving around these themes. One of these main themes "compliance" may be viewed from these three perspectives. The clinic staff consider "compliance" as making good sense from the clinical perspective. Compliance in the clinics mean failing to measure up to the treatment/management regimes proposed by clinics. But the patient and members of the family generally view it differently, in ways more related to various cultural beliefs and values. These beliefs and values revolve around sex, nutrition, witchcraft and ancestors, aspects that lay the foundation for people in organising the ways that health care for diabetes is sought. Hence, the clinics provide an understanding of the rationale behind clinic practices, and the attitudes, assumptions and expectations made about patients and their families by clinic staff. However, this central issue has prompted conflicts expressed in the relationship between the four sets of actors.

Aetiology, the second underlying theme, explains people's understanding of the occurrence of diabetes. Meanings revolve around aetiologies like sex, nutrition, witchcraft and ancestors. This ethnography has revealed a complex network of manoeuvres between the aetiologies, and shed light on the meanings that most people may make about causes and treatments of diabetes. The majority of patients and their families have a strong belief in witchcraft and ancestor-worship. Hence, they still do not completely trust the medical healing world. These are not taken into account in the application of the measurement of compliance by clinical standards on the part of the medical staff. Yet patients and families consider these influences in their own grading of compliance. The traditional healers seem to mediate in resolving these frustrations by offering culturally appropriate treatment alternatives to which many patients and families subscribe. This brings to light the ways in which patients develop self-help management strategies as they strive to understand how to adapt to life with diabetes. Most traditional healers, particularly in Yaounde, seem to understand the cultural changes that motivate the behaviour of patients and their families and adjusted their practices to respond to patients' needs. Hence divination, traditional health protection and herbal treatment is integrated into their services to 'heal' a disease that is thought to be simple to understand. This has even on occasions drawn traditional healers into covertly practising in the hospitals, though in an irregular manner, done to avoid detection by senior staff. But it is a way of convincing many patients and families that modern and traditional diabetes care are two sides of the same coin.

The concept of power, the third main themes that cut through this thesis, is expressed in many ways. 'Power' takes diverse forms and comes in many guises, but it is spread between clinic staff, traditional healers, traditional authorities, the families, witches/wizards and ancestors. Beginning with the clinics, the negotiation of conventional power relations is expressed in the display of biomedical knowledge about care for diabetes by clinic staff. Patients are placed at weaker positions because they are considered as being ignorant of diabetes. They accept the status of ignorance, hide their real feelings about what the clinics offer and reveal them while at home. However, the information received at the clinics is reconstructed within the family and the inability of the clinic staff to propose a cure for diabetes is considered as a weakness. After making sense of the information from clinics and that which they already know, the power of clinic staff is supplemented or replaced by that of traditional healers, precisely because they promise cure. The power of traditional healers is demonstrated through their ability to diagnose and counter witchcraft; and also mediate between families and ancestors. Traditional authorities are brought to light in this ethnography as part of those that produce lay knowledge about diabetes. They are seen as having the power to intercede between the ruled and the ancestors through ritual performances to prevent and ensure a successful cure for diabetes. Hence, most people value ritual performances as vital ways for treating and preventing diabetes. But the style of biomedical rituals may be less culturally meaningful and weaker, therefore less convincing than the traditional ones. On the whole, the ancestors (and supernatural) are considered as supreme retainers of power because every other person is believed to be vulnerable to their actions.

However, examining the issue of compliance purely from a biomedical perspective is misleading. There is a rationale behind every healing decision and action that people take, irrespective of the prescriptions of modern medicine. For that reason, an ethnographic approach to studying diabetes turns out to be the most ideal way of documenting cultural and medical issues about illness. This comparative ethnography has helped me to understand that cultural beliefs and practices about diabetes, in urban and rural areas, which I assumed to be different from the onset, are not necessarily the way I initially thought, because I have identified similarities and differences where I least expected.

1.5 Outline of the thesis

This section summarises the scope and purpose of each chapter, and how they link together. The introductory chapter (Chapter I) develops the aim, objectives and purpose of the study. The chapter explains why I am taking a comparative anthropological approach. The magnitude of diabetes in Cameroon is expounded in which I discuss urban-rural differences. I have also signposted some of the main arguments of the thesis and introduced key concepts which will be important to my analysis.

The background chapter (Chapter II) describes and expounds the two settings of fieldwork: Bafut and Biyem-Assi. It has briefly explained their historical backgrounds,

current administrative and political structures, the organisation of health care; earnings and spending; and urban-rural links and family structure.

The methodology (Chapter III) illustrates the way that ethnography was carried out in Bafut and Biyem-Assi by detailing the process of participant observation and the implications to this particular study and subsequent fieldwork. The first three sections explain the negotiation of access to the research settings and people. They describe the data sources, data types, sampling procedures, data gathering process and the methods. Three subsequent sections focus on the social interactions that I had with gatekeepers and other research participants in the course of fieldwork. They explain the dynamics that went with these interactions, comparing the process of participant observation in Bafut and Biyem-Assi. The last section discusses certain philosophical and ethical issues raised by ethnography generally, which are also pertinent to this particular ethnographic project.

Chapter IV makes a review of some of the epidemiological, medical sociology and anthropology that has been done in the Sub-Sahara African region, laying emphasis on West and Central Africa. I have first examined the state of ethnographic research in Cameroon as a whole, then ethnography in urban areas with main emphasis on Yaounde, where the Biyem-Assi Health District is situated and finally ethnography on the Bamenda Grassfields with Bafut kingdom as the main focus. The review has revealed that most ethnographic studies have concentrated in rural areas with little on urban communities or comparative ethnographic studies and, to a lesser extent, on chronic diseases, especially

diabetes. For the case of Cameroon, the work of Robert Pool (1994) is a good example of rural based ethnography on illness.

Chapter V presents a case study, chosen because it follows one case in some detail and therefore sets the stage for the four ethnographic chapters. It traces the life of a diabetes patient from diagnosis to death. The case study helps in identifying some of the main themes that have been developed in the subsequent ethnographic chapters.

Chapter VI focuses on the work of clinics or hospitals in Biyem-Assi and Bafut where diabetes is treated. The clinical environment is described both as an institution of biomedicine and as a local cultural setting. What comes across most strongly is a sense of frustration on the part of clinic staff about patient behaviour. However, clinics cannot regulate patient behaviour outside the clinic, and the dismay that patients fail to 'comply' with clinic guidelines colours staff attitudes. The whole question of compliance emerges and is complicated by the fact that clinic staff knowledge of diabetes, and beliefs about appropriate and effective treatment, vary greatly. The central paradox that this chapter addresses is why the authority of biomedicine is far from pervasive in the context of diabetes care. Here, I see the work of the clinic as in part a cultural performance to persuade patients to trust and adhere to 'expert' medical knowledge. My ethnography suggests that this performance is not currently as convincing as senior staff would themselves hope.

Chapter VII presents the popular or 'lay' explanations of diabetes by patients and family members. Two main lay viewpoints stand out in this section: firstly that the 'causes' of diabetes are widely seen to be ultimately social, and not purely biomedical; and secondly that diabetes is widely seen as a curable disease. These two lay explanations shape the actions taken by patients and their families to tackle different encounters and conflicts concerning nutrition, sexual activity, and social maladjustment. The issue of compliance has again emerged as one of the main themes of this ethnography, but as responses to the feeling of vulnerability to witchcraft and disobedience to ancestors.

Chapter VIII discusses the different categories of traditional healers that I encountered. I have also discussed the terms by which these healers describe themselves or are described by others. I have discussed beliefs surrounding the aetiology of diabetes, and appropriate or effective forms of response and treatment. I have also examined the healing practices, and what it is that makes healers' performance convincing and reassuring to patients. My ethnography suggests that matters are not quite clear-cut so far as the relationship between clinic staff and traditional healers is concerned. The importance of traditional authority in Bafut has been explored as one of the supporting political-ritual structures that ensure wellbeing and reproduces popular knowledge about diabetes.

In this thesis, I have suggested that most of the discourses relating to diabetes care, acquired from clinic staff, serve poorly for addressing issues of diabetes management. The strong influence of cultural values and norms that greatly influence the ways that

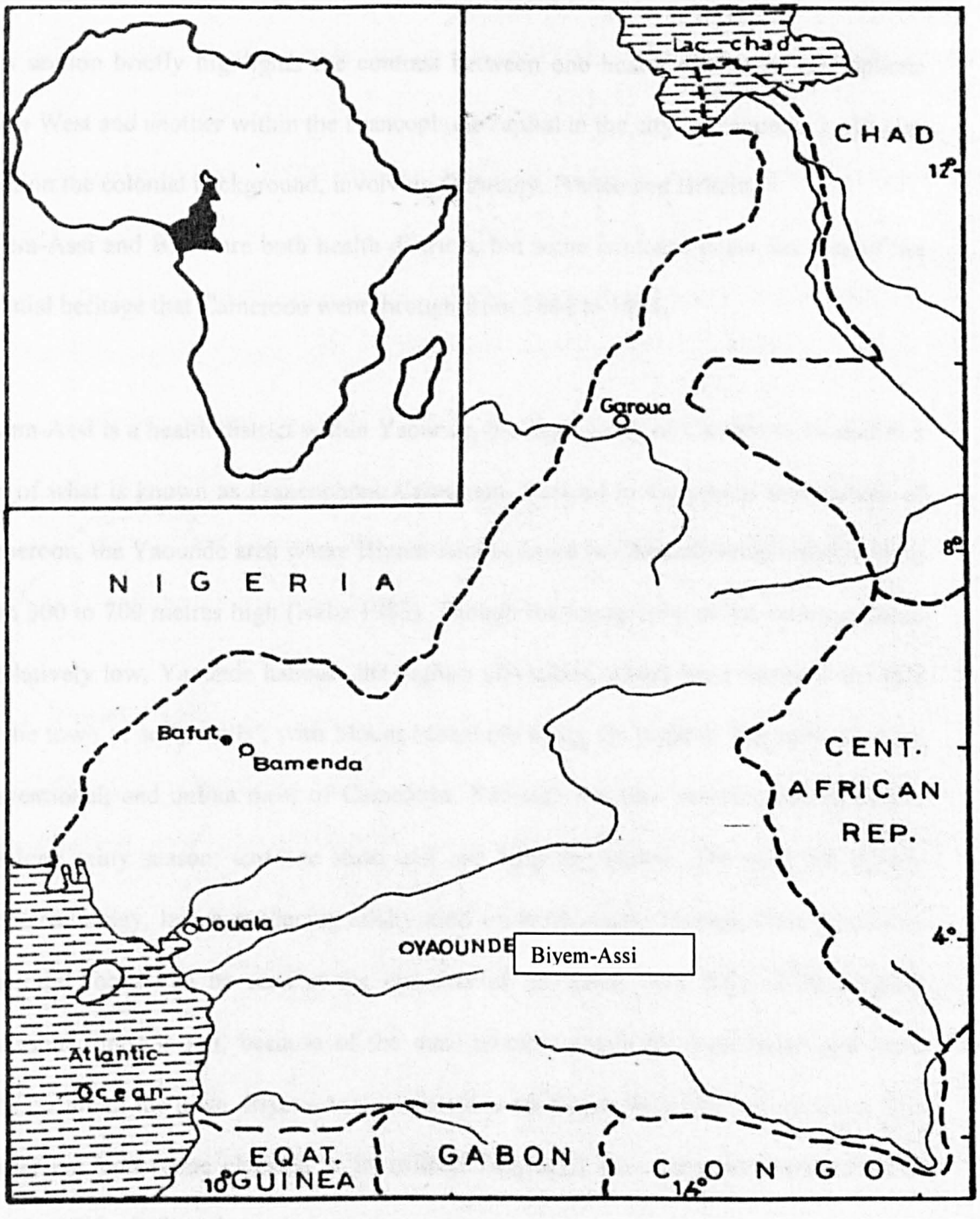
people reach out to heal themselves are often overlooked by clinics. I have examined the interactions between plural medical worlds in a changing cultural landscape of chronic illness in Cameroon and suggested a pathway for doing comparative ethnographic studies on the management of chronic illnesses like diabetes. The study represents the outcome of probing into the tensions and conflicts between the diverse actors in the management of diabetes by health care workers, traditional healers and patients and their family members; tensions which produce the deep paradoxes that frame my work.

Chapter II

Background to Two Fieldwork Settings

2.1 Introduction

This chapter sets out to create a platform on which the rest of the chapters in this thesis will be based. It aims at providing a geographical and social framework about the study setting, highlighting the contrast between Bafut and Biyem-Assi Health Districts, respectively located in the Anglophone North West and Francophone capital city (Yaounde) of Cameroon (See Map 1). I will briefly mention the colonial background, involving Germany, France and the United Kingdom. The next focus will be on issues concerning the historical, current political and administrative structures; earning and spending: work, markets and consumption and urban-rural links in Biyem-Assi on the one hand and Bafut on the other. In addition, because of its relatively homogenous nature, I will discuss the ritual cycle in Bafut, which assumes relevance in this context because without some understanding of it, and the *Fon*'s relationship to this cycle, it is hard to make sense of people's responses to diabetes.



Map 1: A sketch map showing the location of Cameroon in Africa and the locations of Bafut and Biyem-Assi in Cameroon

2.2 The two study settings: an introduction

This section briefly highlights the contrast between one health district in Anglophone North West and another within the Francophone capital in the city of Yaounde. I will also mention the colonial background, involving Germany, France and Britain.
Biyem-Assi and Bafut are both health districts, but some contrasts occur because of the colonial heritage that Cameroon went through from 1884 to 1961.

Biyem-Assi is a health district within Yaounde, the capital city of Cameroon located in a part of what is known as Francophone Cameroon. Located in the central low plateau of Cameroon, the Yaounde area where Biyem-Assi is found has an undulating relief ranging from 300 to 700 metres high (Neba 1983). Though the topography of the central plateau is relatively low, Yaounde habours the highest elevations, which have earned it the title of 'the town of seven hills', with Mount Mbankolo being the highest. The rains here are conventional; and unlike most of Cameroon, Yaounde has four seasons: one short and one long rainy season; and one short and one long dry season. The soils are mainly laterite and clay, hence producing sticky mud on earth roads. Though some secondary equatorial forest can be seen at the outskirts of the town, very little of the original equatorial forest is left, because of the unsustainable nature of exploitation and rapid urbanization of the town. Biyem-Assi is located in the South West of Yaounde town. The district has undergone changes in its official languages from German (1885-1916) to French (1919-1960) and post independence (1961-date).

On the other hand, Bafut is located in the Anglophone North West Province of Cameroon, part of what is called Bamenda Grassfield. It was once a forested area but most of the forest has been destroyed leaving a sheet of palm trees and patches of woodland covering the rolling hills. This territory underwent two different colonial administrations: German (1884-1916) and British (1916-1961), and ended up inheriting the English Language as the official language. However, both districts became independent in 1960 and the reunification of East (Francophone) and West (Anglophone) Cameroons led to the forming of a federated state (1961), then a united republic (1972) and the republic of Cameroon (1984). The judicial and educational policies of Francophone and Anglophone Cameroon greatly contrast, with the Francophone territory adopting French civil and educational frameworks while the Anglophone territory adopts the common law and British educational frameworks.

When, in 1961 a federated state was created joining the two Cameroons together, the two states had separate governments and parliaments from 1961 to 1964 and a federal parliament from 1964 to 1972. The Anglophone state, called the State of West Cameroon, had a bi-cameral assembly and the Francophone state, called the State of East Cameroon, had one assembly. In 1972, constitutional changes[1] led to the dissolving of the separate structures and the creation of a national assembly. The two states were divided into 7 provinces in 1972 and later 10 provinces in 1984. This structure has survived till today,but the name of the state changed from the United Republic to the Republic of

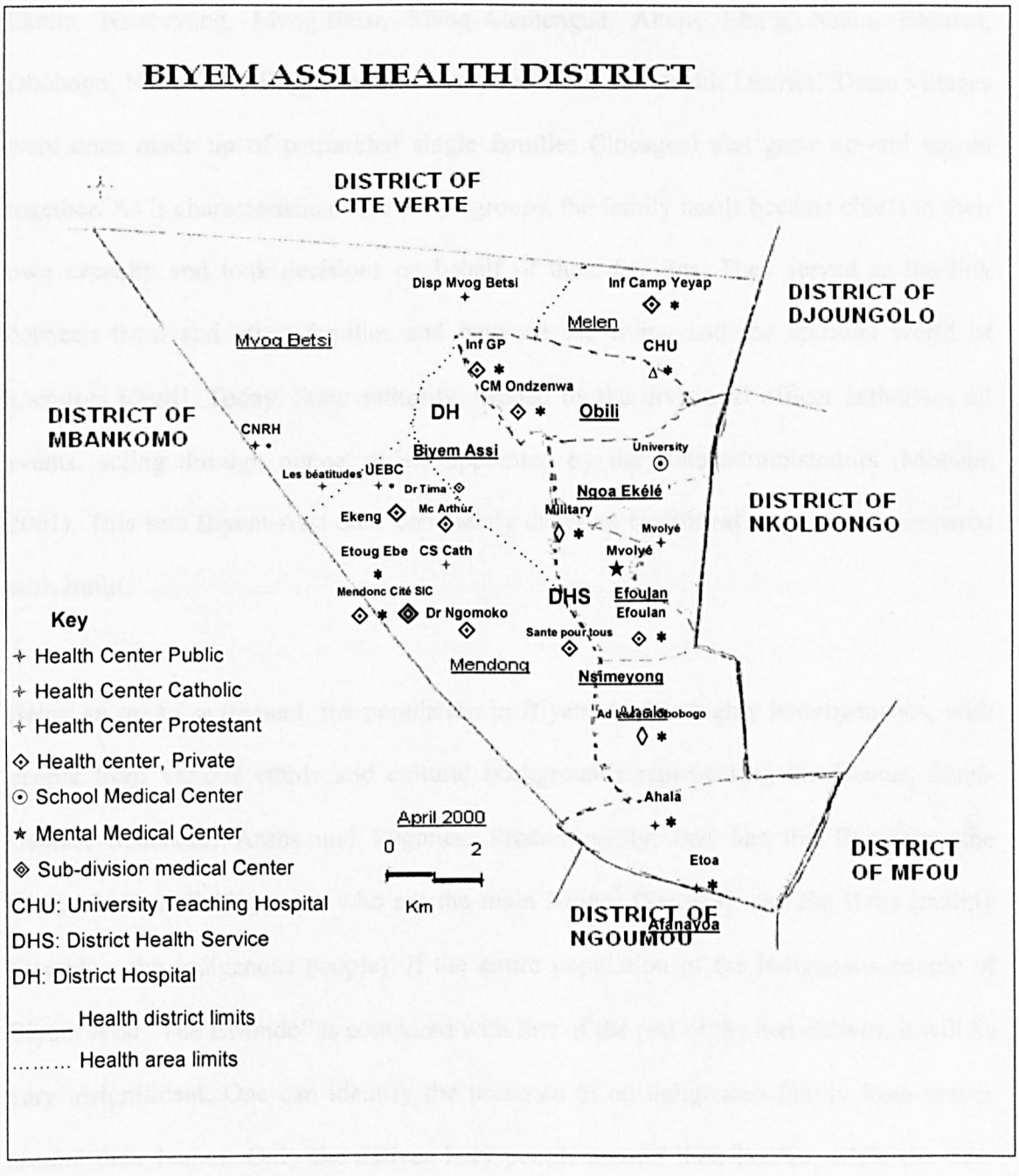
[1] The Federal Republic of Cameroon became the United Republic of Cameroon. The post of Vice President was dissolved and a Prime Minister was appointed to run government affairs.

Cameroon. Following these changes, there has been dissension[2] from the Anglophone part, which claims that they have not been receiving a fair share of the national wealth (Nyamnjoh 2000). This has met with resistance from the Central Government in Yaounde. The leaders of the Southern Cameroons National Council (SCNC), fighting for this autonomy have tabled the case to the United Nations Organisation (UNO)[3] to settle. They have been admitted as part of the United Nations Organisation's Underrepresented People.

2.3 Biyem-Assi

Biyem-Assi is a name in Ewondo Language[4] taken from a river called Biyem-Assi. (See Map 2). This river flows through the Biyem-Assi Health District and empties into River Mfoundi. The name signifies the Biyem valley. Biyem-Assi is the village that was inhabited by the Ba'aba during the Beti migration into Yaounde. The outcome of migration has led to natives (Ba'aba) and non-natives (Beti) inhabiting Biyem-Assi, with the high predominance of non-natives.

[2] The dissension has taken the form of calls for secession for the Anglophone part to gain back its autonomy as a nation, as was before the unification of 1961.
[3] The federation that took place on 11 February 1961 was the initiative of the UNO, which decided that British Cameroons, made up of British Northern Cameroons and British Southern Cameroons (Anglophone Cameroon) [a Trusteeship Territory at the time] were to choose to be given independence by joining either Nigeria or The French Cameroons. The British Northern Cameroons chose to gain Independence by joining Nigeria and the British Southern Cameroons on their part chose to join French Cameroons.
[4] Ewondo is a language widely spoken by a Beti sub-group called Ewondo.



Map 2: A sketch map of Biyem-Assi Health District

Today, Biyem-Assi has grown out of the villages that were located along the Biyem-Assi River valley and merged with Melen, Obili, Etoug-Ebe, Mendong, Simbock, Ngoa-Ekelle, Nsimeyong, Mvog-Betsi, Mvog-Atemengue, Ahala, Eba'a, Nsam, Efoulan, Obobogo, Nkolbikok, Elig-Effa and Mvolye to form the Health District. These villages were once made up of patriarchal single families (lineages) that grew up and stayed together. As is characteristic of the Bantu groups, the family heads became chiefs in their own capacity and took decisions on behalf of their families. They served as the link between them and other families and between the living and the spiritual world of ancestors [dead]. Today, State authority, headed by the divisional officer authorises all events, acting through puppet chiefs appointed by the state administrators (Messina 2001). This sets Biyem-Assi on a completely different traditional stage when compared with Bafut.

Being an urban settlement, the population in Biyem-Assi is highly heterogeneous, with people from various ethnic and cultural backgrounds representing the Bantus, Semi-Bantus, Sudanese, Arabs and Pygmies. Predominantly, one has the Bamileke, the Bamenda Grassfield groups, who are the main *Ntobo*[5] [Settlers], and the Betis (mainly Ewondo - the indigenous people). If the entire population of the indigenous people of Biyem-Assi "The Ewondo" is compared with that of the rest of the non-natives, it will be very insignificant. One can identify the presence of an indigenous family from graves around their homes. Only the natives bury people around their houses, while the non-natives take their dead to their respective villages or public cemeteries for burial. Some of these villages are a few miles from Yaounde and others are several hundreds and even

thousands of miles away. Since rituals accompany all burials, when any of their kin dies, they are taken back to where they migrated from for burial. The reason of returning the dead people to their places of origin is to enable them to meet with the other ancestors, because death automatically qualifies one for a status as an ancestor. In case of any burial rituals, it is in one's village and not in Biyem-Assi that they will be conducted.

2.3.1 Historical background

This sub-section discusses the background to the urban growth of Biyem-Assi, and its ethnic, linguistic and demographic profile. The history of the indigenous people of Biyem-Assi can be traced as far back as three centuries ago, with the arrival of the Ewondos, a Beti sub ethnic-group, to settle in Yaounde. But the oldest indigenous people who settled there were the Pygmies (Maka) who were later displaced because of pressure from immigrating groups like the Ewondos. The Ewondos, like other Betis, are said to have migrated from the western highlands in 1717, just before the Fulani invasions of the 18th century. They crossed the River Sanaga and moved eastward to Yaounde. The Betis today comprise roughly one half million people, divided into the Ewondo, Bulu, and Eton clans (Mveng 1963, Messina 2001).

On the arrival of European traders and missionaries these villages started to expand with the influx of people into Yaounde. When the Germans colonised Cameroon, they discovered a form of centralised administration with the Grassfield chiefs, and administering the grassfield territory looked easier to them. But this was not the case with the forest areas because villages were made up of families having little to do with each

[5] Ntobo means stranger or settler or non-native in the Ewondo Language.

other and lacked a centralised government. The German colonial administration appointed one of the family heads "Atangana" also known as Miyeme Meyonne, as paramount chief of the Ewondo and called him Charles Atangana. He served the Germans and acted as a link between the German Colonial Administration and the indigenous people. His kin gave a lot of spiritual attributes to Charles Atangana to act in that capacity. Charles Atangana died in the 1930s and the cohesion of his territory broke apart. His death set the clocks back and a centralised traditional government amongst the Ewondo ceased to exist (Mveng 1963, Messina 2001)

With colonisation there was an influx of people from other ethnic groups into Yaounde to serve in the German and French administration. The city was a Francophone city. From 1961, people from Anglophone Cameroon became part of this immigration to work in the centralised institutions like the University of Yaounde, the federal parliament and federal ministries. The trend increased with the dissolving of the West Cameroon structures. Biyem-Assi had fewer people living there until the 1980s when new layouts were mapped out for people to settle. Many people of various ethnic backgrounds acquired land from the native Ewondo and constructed homes. Others have settled for business and rent some of the homes. This settlement process is ongoing and today, there is a mixture of most of the ethnic groups found in Anglophone and Francophone Cameroon.

Despite some group differences, the Ewondo language[6] is the common thread that unites the Beti group. Besides speaking a variety of local languages of the Western Grassfield (Bamileke and Bamenda) and Beti (Ewondo), people also communicate using French, English and Pidgin English.[7] However, local languages are mainly used in homes, family, tribal and ethnic associations.

2.3.2 Current administrative and political structures

The expansion of Yaounde accelerated after independence and more urban characteristics were acquired, including division into administrative units of which the Biyem-Assi area is one. This first gave the area an administrative unit called Yaounde III; and most recently (in 1992), Yaounde III was divided into Yaounde III and Yaounde VI. From 1995, when Cameroon government started the decentralisation policy in the health sector, Yaounde III and Yaounde VI were grouped into the Biyem-Assi Health District. The Biyem-Assi Dispensary was transformed into the District Hospital and that of Efoulan into a Sub-divisional Hospital. In 2003, the health district was further divided into two: Biyem-Assi and Efoulan Health Districts with different resident district medical officers (DMO).

[6] Ewondo is a Bantu language spoken by the Ewondo. The Ewondo language had been used in the central plateau of Cameroon, now Centre, East and South provinces, by the Germans during their colonial rule, as a language of instruction and evangelisation among the Beti, Bulu, Fang and Maka.

[7] Pidgin English is the Lingua Franca in Cameroon like most West African Countries widely used for business and communication. The use of Pidgin stems from the fact that the British and Germans first used the language for missionary and trading prior to colonisation. An elderly person from any other region of Cameroon, who can speak neither English nor French, is proficient in Pidgin.

The Biyem-Assi Health District is one of the 25 health districts located in the Health Province of the Centre Province of Cameroon. In Yaounde, it is located alongside other health districts like Nkolndongo, Cite Verte, Djoungolo and Efoulan. The Biyem-Assi Health District has a population of 422,522 (MOH, 2004). There are 25 general practitioners within the health district, 17 specialised medical doctors, 11 pharmacists, 7 hospitals, 13 health centres and 12 pharmacies - both public and private (MOH, 2004). The Biyem-Assi Health District has 11 health areas in which 21 health units are unevenly distributed. Five health units (Etoug-Ebe Baptist Health Centre, the Djoungolo Annex Presbyterian Health Centre, the Military Hospital and the Biyem-Assi District Hospital and Marie Immaculate Health Centre) provide care for diabetes and its risk factors. Their creation respectively dates from 1999 (for the first two) and 2001 and 2004 respectively. These health units have pools of diabetes and hypertension patients that are regularly followed up at least once a month.

But how have these clinics come to be created in Biyem-Assi? In 1998 Professor George Alberti of the University of Newcastle upon Tyne Medical School obtained a grant from the UK Department For International Development. Through this grant, and with the leadership of Professor Jean-Claude Mbanya, the Faculty of Medicine and Biomedical Sciences conducted a survey on non-communicable diseases (NCDs). The project was branded as Cameroon Essential Non-communicable diseases Health Intervention Project (CENHIP). Asthma, diabetes, epilepsy and hypertension were the NCDs considered in the survey. At the time, there were no Primary Health Care (PHC) services for these diseases and many new patients diagnosed during the survey could not afford the cost of

care in the tertiary hospitals in Yaounde. The data generated by this survey was used to establish a model by which Primary Health Care (PHC) could be provided for these NCDs. The project therefore created two clinics at the Etoug-Ebe Baptist Health Centre (EBHC) and the *Eglise Presbyterienne Hôpital de* Djoungolo Djongolo Annex (EPHC) to care for these patients. These clinics served as Primary Health Care Units from which models were developed. From 1999 to 2003, these models, treatment guidelines, protocols and training manuals were piloted in another project named Action on Non-communicable diseases in Sub-Sahara Africa (ANSA). Two additional clinics were created. These clinics currently serve as Primary Health Care clinics for diabetes and hypertension care. However, there are gaps in the care of patients because of the inadequately trained staff, as a result of the fact that diabetes care is not yet a main module in the curriculum of training schools and in the work plans of health facilities. Only the very few staff trained by these projects have an idea of what it takes to care for diabetes. The untrained staff are as ignorant about diabetes as lay people. The health facilities that have embraced these innovations are mainly Church run ones because of their charitable organisation and their fairly independent way of organising health care from that set out by government. The government facilities still lag behind in taking up these innovations because of the absence of a policy and an ongoing public health programme for the care of diabetes. Generally, health facilities where these clinics are absent do not have diabetes in their health care agenda.

2.3.3 Earning and spending: work, markets and consumption

Biyem-Assi started off as a village, then a commuter residential area but today has a lot of commercial activities. The first university in Cameroon, The University of Yaounde, is found here. Though there are two markets in Biyem-Assi, many supermarkets and provision stores compete alongside, leading to price wars in many occasions. The population co-exists with multiple bars and shops dotted here and there. Formerly, the law in Cameroon prohibited the location of bars at a distance of less than 100 metres apart but the liberalisation policy has made it possible for many bars to be located in the same building, provided there is space to accommodate all. Beer is even sold in the open air. The only drink that is prohibited from being sold is the locally brewed *Odontol* [gin], though its production and circulation thrives well in enclave parts of the town and in the black market. It is easier to see an off-licence [where alcohol is sold] than a provisions store.

Most of the fresh food sold in the markets comes from outside the Mfoundi Division; the main sources being the Lekie Division, North West and West Provinces. These are mainly tubers, vegetables and fruits, but expensive for low and middle-income people to buy. The phenomenon of junk food is emerging in Biyem-Assi and is generalised in the city of Yaounde. Varieties of food are eaten and each family eats staple food according to its cultural background and prescriptions. However, menus like *Eru, Coki, Achu* and *Yellow soup, fufu corn and njama,* well known high fat content foods, are widely eaten by people, irrespective of their cultural backgrounds. The population is increasingly consuming lots of imported meat, fish, chicken and canned or processed food. In the

United Kingdom and other western settings, the packaging of this foodstuff specifies an expiry date. It is not the case with what obtains in Cameroonian markets. So far as they are not decaying, they can be eaten. Frying food is the order of the day; hence, vegetables and some staple food like potatoes and plantains are fried. People are gradually abandoning their original feeding habits for those they qualify as *modern*. The staple food to the Beti is *pwem*[8] while the Bamilekes eat *condry*[9] and *coki*.[10] People from the Bamenda Grassfield have two main meals *Achu*[11] and also *fufu corn*.[12] Today, the preparing of these meals has witnessed a lot of changes. In cooking most of these foods oil is used to fry.. Other varieties of food are prepared but in ways so as to have them contain much oil, as a way to display wealth.

Many people leave the district to work in other parts of the town of Yaounde creating a transport problem. The residents are mainly traders, housewives, school children and civil servants. Farming in Biyem-Assi is rare except in the far-off hills where a few people hire land for that purpose. But most of this cultivable land is being bought for the construction of houses. Most people here live sedentary lifestyles probably because of the lack of facilities to enable them keep fit. The activities here are mainly tertiary so intensive physical activity are not part of daily life.

[8] Pwem is boiled cassava leaves cooked with groundnut without salt and eaten with cassava or plantains.
[9] Condry is boiled bananas with groundnuts paste and meat.
[10] Coki beans is beans paste prepared with palm oil and other ingredients.
[11] Achu is pounded colocassia and well spiced soup prepared with oil and dried meat.
[12] Fufu corn is corn paste prepared with corn flour and eaten with hucklebury that prepared with a small amount of oil and with or without salt.

Cameroon has more than 25 different brands of beer. This is in addition to locally brewed palmwine, local and imported gins and red or white wine. The success of a feast is judged by the amount of alcohol that is drunk. Funerals, death celebrations, marriages, birthday parties and others are occasions where people expect to eat and drink. The rate of alcohol intake in Biyem-Assi is 60-70%, respectively for men and women (Mbanya et al, 1999). Hence, more men than women have a higher rate of alcohol intake. Most people live in rented homes, buy food from the market and consume industrially brewed beer. This leaves people in Biyem-Assi with less income to spend on alcohol as part of their income is set aside for rent and food.

2.2.4 Urban-rural links and family structures

The family structures of people in Biyem-Assi are mainly nuclear but the village-town link obliges some residents to add some of their kin to their households, thereby increasing household density. Most marriages are monogamous because the urban lifestyle makes it difficult to run large polygynous families. Most people do not settle in compounds or according to family accessibility to land, as is the case with villages. Rather they rent property in which they live and can move from one part of the town to the other. The wealthy residents have constructed homes for themselves. However, ethnic groups of Bamileke and Bamenda Grassfields have the tendency of acquiring land in an area and looking for possibilities for their kin or people with similar ethnic backgrounds to join them, thereby creating clusters of people with the same ethnic backgrounds in some areas of the town. In such places, the village landscape and some of the social

stratification is reconstructed and established, enabling the performance of some rituals particular to their motherland.

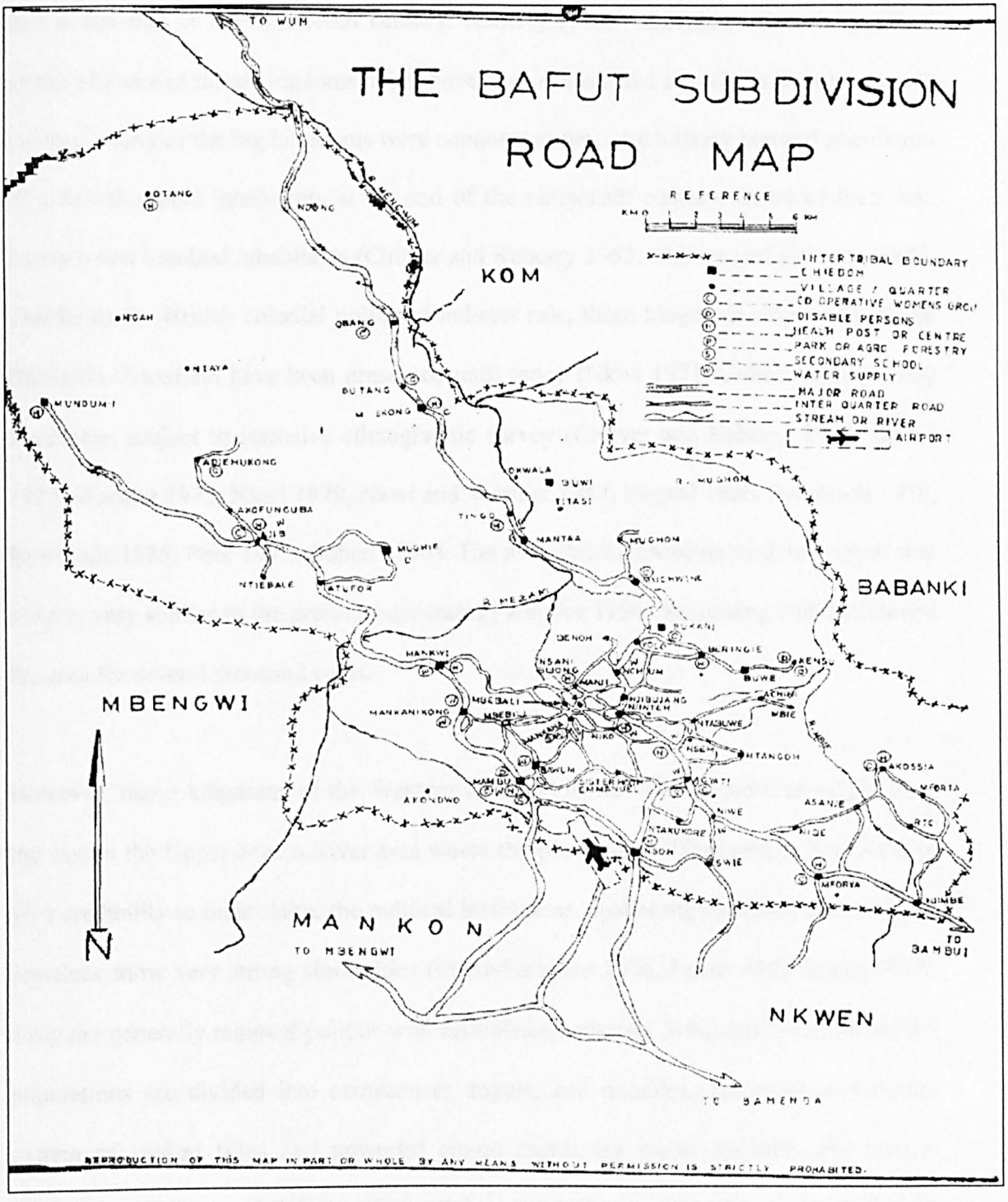
People's villages, though seeming to be far from them, form part of their urban life. The village landscape is reconstructed in the town as people organise themselves into associations based on family and ethnic lines. These associations provide the required social support and security. Social security schemes[13] are established by members of these associations, who at the same time act as checks to any conflicts that may arise within families or between the members. Despite all these arrangements, people endeavour to maintain a very cordial relationship with their families back in their villages. Most people return to their villages for rituals, provide assistance to parents and mend any conflicts that may arise between them and their kin. A person in town can decide to sponsor his kin or provide his parents, brothers and sisters in the villages with some basic financial and material assistance. This act is to strengthen family ties and please these people who usually act as spiritual and political leaders within the family. Many of these people are lineage heads who are retired and have little or no education. They have spiritual powers that enable them to interact directly with family ancestors so are always consulted by those living in the towns. Their social positions enable them to plead the courses and perform rituals for those living in the towns. Some residents of Biyem-Assi are successors and family heads back in their respective villages so make rounds of visits to their villages to perform rituals and exercise their spiritual and political powers.

[13] The Social Security Schemes are called *Njangis* by the Anglophones and *Tontines* by the Francophones. They are trusts set up by people with a common interest to cater for their social and financial needs at difficulties moments.

2.4 Bafut

The Bafut Kingdom is situated about 14 miles North West of Bamenda and 285 miles to the North West of Yaounde. Bafut is *Biifii*, meaning people who have been enclosed. It has a total land area of about 2847 square miles with an average density of about 14 inhabitants per square kilometre. According to the health census of 1999, it has a population of 74,750 inhabitants (MOH, 1999).Bafut is settled in three main zones and is actually a composite of different ethnic groups. At the centre are the people of *Mumala'a* (heart of the country) clustered around the *Nto'o* [*Fon*'s palace] who refer to themselves as the real Bafut. This name is applied to the whole kingdom. To the south is the Ntare (ridge) area covering villages like: Mankwi, Mankanikong, Mambu, Bawum, Mundum and Akofunguba. The north is the Mbunti (lower) area, which descends abruptly to the Menchum River valley. Here you have Tingoh, Obang, Mbakong, Butang, Kwaala, Buwe, and Bukari (See Map 3).

One cannot fully understand the history of the Bafut people and other grassfield kingdoms like Nso, Kom, Nkwen, Bum and Nsungli without making a brief allusion to the Grassfield. The Grassfield is the name given to the highland savannah region of Cameroon. The Grassfields correspond approximately to the West and North West Provinces and lie immediately north of the tropical forest zone, between the Cross and Benue Rivers on the border with Nigeria (Kaberry 1952, Chilver and Kaberry 1962, Chilver and Kaberry 1968). Bamenda, the provincial headquarters of the Northwest Province, is situated on a plateau almost in the centre of the region. A number of



Map 3: Sketch map of Bafut Sub-Division corresponding to Bafut Health District

kingdoms of differing sizes, origin and complexity crystallised on this plateau prior to and at the end of the nineteenth century. Kaberry (1952) speculated that the political nuclei of some of these kingdoms might have been established as early as the seventeenth century. Many of the big kingdoms were conquest states, which likely boasted population of a few thousand inhabitants at the end of the nineteenth century. Some of them had barely a few hundred inhabitants (Chilver and Kaberry 1962, Chilver and Kaberry 1968). Thanks to the British colonial policy of indirect rule, these kingdoms, especially of the Bamenda Grassfield have been preserved until today (Nkwi 1971, Goheen 1996). They have been subject to intensive ethnographic survey (Chilver and Kaberry 1968, Dillon 1973, Warnier 1975, Nkwi 1979, Nkwi and Warnier 1982, Engard 1986, Rowlands 1979, Rowlands 1985, Pool 1995, Gohen 1996). The available archaeological data suggest that people, very similar to the present inhabitants (Warnier 1984, Asombang 1988) occupied the area for several thousand years.

However, many kingdoms of the Western Grassfields, like Bafut, claim an origin from the east in the Upper Mbam River area where the present-day Tikar people live. As if to give credibility to their claim, the political institutions, spatial organisation, and religious practices show very strong similarities (Chem-Langhee 1976, Fanso 1988, Ngoh 1987). They are generally regional polities with centralised authority. Kingship is sacred and the populations are divided into commoners, royals, and notables. There is an elaborate system of ranked titles and powerful closed regulatory secret societies and princes fraternities (Chilver and Kaberry 1968, Chilver and Kaberry 1971, Geschiere 1993). The palace is both the focal point of political, religious and ceremonial life and the

headquarters of the principal secret societies. State established administrators always almost find themselves redundant in some of their functions, as the traditional authority is more respected (Goheen 1996). As Kaberry (1962) points out, this combination of sacred kingship with palace associations having governmental duties is quite unique to this region of Cameroon. But the palace is also the cosmological centre and focal point around which larger than usual populations congregate (Kaberry 1962, Asombang, 1999). Bafut is one of the grassfield Tikari groups with strong established tradition and belief systems.

2.4.1 Historical background to the Bafut kingdom

The Bafut people migrated into the Grassfield area under several leaders and at different times. Most of the people of Bafut fall under the Tikari tribe. The migration of the Bafut people from Ndop has been attributed to disputes of succession, which resulted in the disintegration of the group. Another faction moved to other parts of the North West Province. Yet another faction moved to settle on the small hill called Mbebeli in present day Bafut about 1516 (Ritzenthaler and Ritzenthaler 1962, Nebasina 1973, Asombang 1999). These newcomers found out that some people had earlier inhabited the small hill so they settled with them peacefully after offering them gifts. Another group, the Buwe Bukari, was already settled in the lower part of Bafut but the two early settlers seemed not to have established any contact with each other. The Buwe Bukaris are believed to have found their way into this area through the Menchum valley. Another group of migrants into the area include the Bawum who claimed to have come from the hills of Bamenda Station; that is, around Bamendakwe. The people of Mambu claim a Widikum

origin and passed through Mundum to Bafut. The only recognisable early settlement where the various migrants conveyed was Mbebeli supposed to be the earlier settlers of present day Bafut under the leadership of Neba Chi (Kaberry 1952, Chilver and Kaberry 1962, Chilver and Kaberry 1968).

In 1518, two years after settlement in Mbebeli as a result of the rocky and hilly nature of the area, a princess by name Ndelahmbue went out for farming and fishing where she found a level land. She reported to the *Fon* and after serious investigation the people decided to move to the level land which is where the present palace is located. During their departure only part of the population moved to the present site because of chieftaincy disputes. At this time power was seized from Neba Chi by *Fon* Abumbi I. Many people supported him because he was generous. As a result, many people moved to places like *Ntohmuwi* of Niko quarters, *Ntohnta'a* of Njibujang quarter that later moved to Nkwen. The Bafut people assassinated[14] Ndelahmbue in an organised coup staged at *Nsanimunwi.* The reasons for the act were to put an end to the respect she gained from many people. It was feared that she could pull the entire crowd to her side and power

[14] The circumstances of the assassination of Ndelahmbue were that a feast was organised in her honour as the one who discovered the present site of the palace. At Nsanimunwi, a very deep hole was dug just behind where butchers display and sell meat. On that day, the place was properly decorated and the hole covered, such that no one could know that there was a hole there. A chair was displayed above the hole for her to sit immediately after the decoration. After honouring her, she was taken to the seat prepared for her. She sat on it and the chair sank into the hole. She was immediately buried "alive" in the hole. People believe that her spirit keeps haunting them since then. Today, one of the princesses who hails from that lineage has been appointed and crowned by the palace as a way to appease her spirit. The crowning of her successor is a way to keep off all the misfortune, which Bafut people think delay their progress and is responsible for all incurable diseases and misfortunes like diabetes.

might one day be handed to her, as it happened with Nebachi and Agha-Njo (Chilver and Kaberry 1963, Chilver and Kaberry 1968).

Through a process that is still poorly understood, the relocation of the palace coincided with the disappearance of the segmentary proto-state system, in favour of the development of a state system with centralised political, religious, and social institutions. This was an important turning point in the building of the present Bafut Kingdom. It marked the beginning of economic prosperity through involvement in local and long-distance trade (Rowlands 1979, Engard 1988). It also marked the beginning of rapid expansion through standards of living and population. The neighbours considered Bafut expansion to be so rapid that at the time of first contact with Europeans (1889-1901), she was militarily formidable and engaged in many wars fought to subdue them (Chilver and Kaberry 1963, Engard 1988).

In the course of all these events, the language of the Bafut people evolved, absorbing those of the Mbebeli and Bawum. The Bafut language is classified within the Mbam-Nkam section of the central branch of the Niger-Congo family along with other nearby languages such as Bali Nyonga, Bamum and Pinyin (Voorhoeve 1971, Neba 1995). There are groups within Bafut, which speak languages entirely different from Bafut. The villages of Mundum, Obang, Botang, Buwe, Bukari and Kwala are mainly of Widikum origin; and have rituals and languages, which are completely different from those of Bafut. Those cultures I describe here are those of the "real" Bafut where I limited my fieldwork.

2.4.2 The political and administrative structure of modern Bafut

This section shows how state structures at the local level stand alongside, and overlap with, traditional structures. I ponder over the issue of how the political importance of the *Fon* is waning though still strong; and the checks and balances that curb the *Fon*'s power, including the place of the secret societies. I also briefly expound on the organisation of health care.

Bafut is a typical area where state structures at the local level stand alongside, or overlap with traditional structures. The traditional structures have existed since the founding of this kingdom but for quite a while the political importance of the *Fon* has been waning. This is as a result of former vassal states within these kingdoms claiming autonomy; and the state administration reducing *Fons* to traditional and ritual roles. (Nkwi 1979, Neba 1995) There are a couple of checks and balances that curb the *Fon*'s power. Though the *Fon*'s actions apparently seem to be controlled by traditional secret societies, a mechanism has been devised by which he, in turn, dictates what they have to do. Like other Grassfield Kingdoms, Bafut has a mixture of both traditional and modern administration, each retaining a considerable amount of authority over her activities. But the waning nature of traditional authority is very apparent and this contributes to conflicts between traditional and state administration. Traditional powers have been reduced to secrets and rituals; the state taking over the legislative, judicial and economic ones (Nkwi 1979, Fisiy 1996, Jua 1996, Mope Simo 1996) .

Bafut is equipped with several institutions that maintain law and order at different structural levels. In Bafut, the kingship is sacred, meaning that the political organisation is centred on the *Mfor* or *Nfor* [king], better known locally as *Fon*. He is titular leader with political as well as ritual powers associated with the fertility and welfare of the land and the people. The *Fon* is a member and head of all secret societies and chief priest of the cults and shrines. He is the dispenser of honours and installer of successors. Because he is ritually installed, it is believed that he takes on immortal attributions; he is never ill, it is the palace that is cold; he never dies, he disappears or is lost or fire goes out. Therefore, the *Fon* means more than just a leader to his people. He is seen as a living god, feared, respected and honoured given that he is closest to the gods and the ancestors. The *Fon* can be held responsible for all successes and failures in the kingdom so he does all to satisfy his people and create social harmony.

For the purpose of effective government, Bafut is divided into villages (*Nekuru*). The latter are further divided into *Ayeunda* [wards]. Settlement is by lineage in a unit of space called a compound. An *Atangcho* [sub-chief] governs a village, which has the status of sub-chiefdom, but generally, *Butabunekuru* [a council of elders or village heads] governs villages. Alongside these traditional administrative structures, a general characteristic of Bafut society is its distinction between royals, notables and commoners. This system of ranked titles is inextricably tied to the number of secret societies[15] that constitute the core

[15] In one of my dialogues with the Fon of Bafut and some elderly people they revealed that there were three powers in Bafut: the Fon, the *Kwifor* and the Takumbeng. Allusion is not made to *Chong* as it is considered as part of the Fon's entourage.

of the political and spiritual structure. The most important secret society is *Kwifor*[16], whose membership is open only to commoners and people of distant royal descent. The next most important society is the closed male princes' fraternity – *Chong*[17] (Asombang 1999). The other groups like the *Takumbeng*[18] are made up of outsiders. There are many other societies which one is expected to join on becoming a member of *Kwifor* or *Chong*. All the societies have their headquarters in the palace. This centralisation consolidates the power base of the palace and the asymmetrical position, relative to one another, of the *Fon* and *Kwifor*, who execute that power (Engard 1986, Engard 1988, Asombang 1999). Bafut is a society where wealth and success in life are expressed in terms of the number of secret societies to which one belongs and the titles purchased in them explain the attachment that people have to these institutions.

The relationship between the *Fon* and *Kwifor* is rather intricate and at times conflictual, with one avoiding sanctions from the other. In practice, however, it is a relationship of mutual respect and co-operation. Even with its wide-ranging powers, *Kwifor* sometimes appears to play only an advisory role or is seen as supporting the *Fon*. Similarly, the *Fon* is quite often referred to as the son of *Kwifor*. So the two articulate very well in practice rather than being a check on the other. It is this institutionalisation of the sacred and the judicial that constitutes the power base of the kingdom. Nevertheless, the *Fon* is the only

[16] *Kwifor* is the executive arm of government with wide ranging powers, including the power to depose an ineffective or malfeasant *Mfor* [king]. In pre-colonial times, *Kwifor* also had the power to inflict capital punishment. Since its authority is impersonal, its agents could not be held to account. With the advent of the modern state of Cameroon, the government alone is empowered to administer capital punishment. This is the most significant change that *Kwifor* has witnessed since the segmentary proto-state.

[17] The *Chong* society is only indirectly political and has no executive powers. It is an assembly of princes, with functions to protect royalty and maintain the status quo, therefore part of the *Fon*'s cabinet and not a power per se. They are his brothers and advice him on how the palace should be run.

person that interacts directly with the other two powers since he is primus interpares. The local subjects can only belong to one of these. Princes have nothing to do with the *Kwifor* and do not see it. Just like the members of *Kwifor* are not supposed to see the *Chong*.[19] There is some misfortune by way of an incurable disease, like diabetes, if one sees what one is not supposed to see. However, these beliefs exist in an environment alongside modern health facilities.

There are three medical doctors, of which two work at the district hospital and another at the Catholic Health Centre Mambu. There are ten health units distributed in eight health areas. Each of the health units has a pharmacy run by the North West Special Fund for Health that should ensure the availability of drugs in all health units of the public sector but this is far from being the case with NCD drugs.

2.4.3 Earning and spending: work, markets and consumption

Bafut is mainly an agricultural area, therefore, a peasant community. Most people in Bafut own farms. The few people who are involved in commercial activities, still farm as a secondary activity. It is easy for someone in Bafut to be a farmer, a trader, a wine taper and an oil producer or a combination of many other activities. Even those involved in tertiary activities like service provision such as civil servants, teachers, nurses, council workers have farming as part-time jobs. The days of leisure are spent in the farms mainly

[18] *Takumbeng* plays a more active (regulatory) role at some cults like pollution removal, purification, and fertility rites.

[19] There is a myth of how an entire family was completely wiped out after seeing *Chong*. It is only when some purification rites were performed that the diseases in that family stopped and people were not longer dying.

to cultivate tubers [cocoyams, colocasia][20] and palm oil. Small-scale cash crop cultivation of palms,[21] ginger and rice is practised in a diversified manner. The cultivation of vegetables is at a very small scale, so vegetable retailers bring in most of the vegetables sold from Bamenda town. Most of the coffee farms that used to exist are now lying fallow, given that the world market prices have discouraged people from still working in the coffee farms. Though there is some division of labour, the women tend to be more physically active than the men. Most of the agricultural activities are carried out by women while men stay at home waiting for them to return, fetch water, cook and feed them. Meanwhile a few of the men who own palm bushes spend some time collecting the nuts to produce palm oil and also tap palmwine in the early hours of the morning. Most of the palmwine is sold to retailers and some is set aside for socialising during the day. Embroidering of traditional gowns of the Bamenda Grassfield is mainly an activity that takes up time for a few of the women. The eating habits of the Bafut people are more similiar with those of its neighbours and less with those of their Tikari (Kom, Bum, Nso and Nsungli) brothers. The staple food here is *Achu*[22] prepared with a tuber called *Corocasia*.

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[20] The colocasia is used for preparing "Achu" the staple meal of the Bafut people.

[21] Palm oil, palm kernel and palm wine are produced from the palm tree and diversely used for subsistence and commercialisation.

[22] The colocasia is cooked, the shells taken off and then pounded in a mortar using a pistil. The pounding takes more than an hour to avoid lumps enabling you to swallow them without chewing. A few people have tried to introduce machines that could grind the *Achu* for the mixing to be done later but it is believed that such an *Achu* is not delicious. *Achu* is prepared and wrapped in leaves for storage, which formerly could be stored for a week. The *Achu* soup is spiced with 12 different spices collected from the forest or bought in markets around Bamenda. Much oil is used to prepare the soup. The prices of oil vary according to seasons. Oil is cheaper during the rainy season and more expensive during the dry season. In moments of abundance in oil, more oil is added to the soup and during periods of scarcity, the amount of oil in the soup reduces. Alternatively, some people like eating *Achu* with soup prepared from the *corocasia* leaves but this is perceived as being an expression of poverty.

In Bafut, like most of the grassfield, feasting is called, '*Allah*'.[23] When I heard *Allah* in Bafut, I at once knew that there was a feast somewhere. Bafut children are not exempted from drinking, especially *Moluh* [palmwine].[24] When a child is delivered, he has to drink some '*Moluh*' to protect him/her from any diseases. All this is done with the belief that *Moluh* [palmwine] is non-alcoholic whereas it is. Alcohol in Bafut like many communities in Cameroon means beer excluding palmwine. This leaves the area with an alcohol consumption rate of 80 and 90% in Bafut for men and women respectively (Mbanya et al 1999).

2.4.4 The ritual calendar in Bafut.

A year in Bafut, like many other Grassfield Kingdoms, is marked by a ritual calendar even though different in types and purposes of rituals. The palace of Bafut is where most of the rituals are planned, executed and their impact assessed. This is where most ritual life begins and extends to the other quarters and chiefdoms and/or ends. In all cases decisions on the dates of these rites are taken in the Palace. There is a movement to and from the Palace and the quarters/villages. Everyday one sees members of the three powers of Bafut in the palace trying to prepare grounds for rituals. Asombang (1999) explains that all ritual life begins in the palace but I think it is only in some cases. I will take some of these rituals and explain the circumstances and possibly the period of the year that they are performed.

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[23] *Allah* is not a word of any language in the grassfield. It is borrowed from the Muslim word, *Allah* referring to Muslim feasts, during which there is always much to eat and drink for all.

[24] Palmwine [*Muluh*] is considered to be both nutritive and medicinal. Rituals are performed with palmwine in most Cameroonian ethnic groups. Traditional medicines are prepared with palmwine. It is also believed that drinking palmwine stimulates the child's milk in a mother's breast so she is given much of it at birth. A child is protected from having diseases and eye problems when he/she drinks palmwine. Palmwine,

The beginning of the dry season is the beginning of the ritual cycle in Bafut (Asombang 1999). This is usually in mid-November when the *Takumbeng* ritual is organised. *Takumbeng* keeps the spiritual powers of Bafut. Every year, within a scheduled week in the month of November, quarters and villages meet at their respective *Nsanis*[25] to prepare medicine that is taken to the palace. On the opening day, young boys get up in the morning, set out for the hills to collect grass required for constructing the *Nebeuhs* in the *Nsanis*. In the course of this, they blow air into broken bamboos and produce a frightening noise to scare all women and announce the arrival of *Takumbeng*. Rituals are first held at the *Nsanis* in quarters and villages on this first day. At this occasion, every quarter reconstructs and decorates the *Ndéré* [*Takumbeng* hut] at its *Nsani* with all what the hands can make.

Takumbeng has two main rituals: *Mfeenu* [the pollution removal rite] and *Mundeughe*[26] [the laying of protective ropes across road junctions] (See figure 1) to protect Bafut from evil from other kingdoms. A one-week preparatory work is done in all the *Nsanis* of the villages and quarters. On the last day of *Takumbeng* and as early as 4 am, a "talking drum" is played in the palace and the *Takumbengs* of the other villages assemble in the palace. The last of this must arrive by 5am.

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therefore, has a very high value in all Cameroonian cultures as it is used for rituals, nutrition and health care.

[25] *Nsanis* are the ritual and political foci of villages in the same way as the palace is the political and ritual focus of Bafut.

[26] The protection ritual called *Mundeughe* entails the lying of a protected medicated rope across the junctions of roads linking Bafut to other kingdoms. These ropes are also laid at village dance grounds, entrances to compounds of important people "big men" in Bafut and as usual in and around the palace. These ropes are believed to close Bafut from all evil influences, diseases or witchcraft that may be perpetrated by enemy kingdoms or individuals. To place a rope across the road symbolically locks the road so that any evil influences will stop at it or be destroyed if they cross.

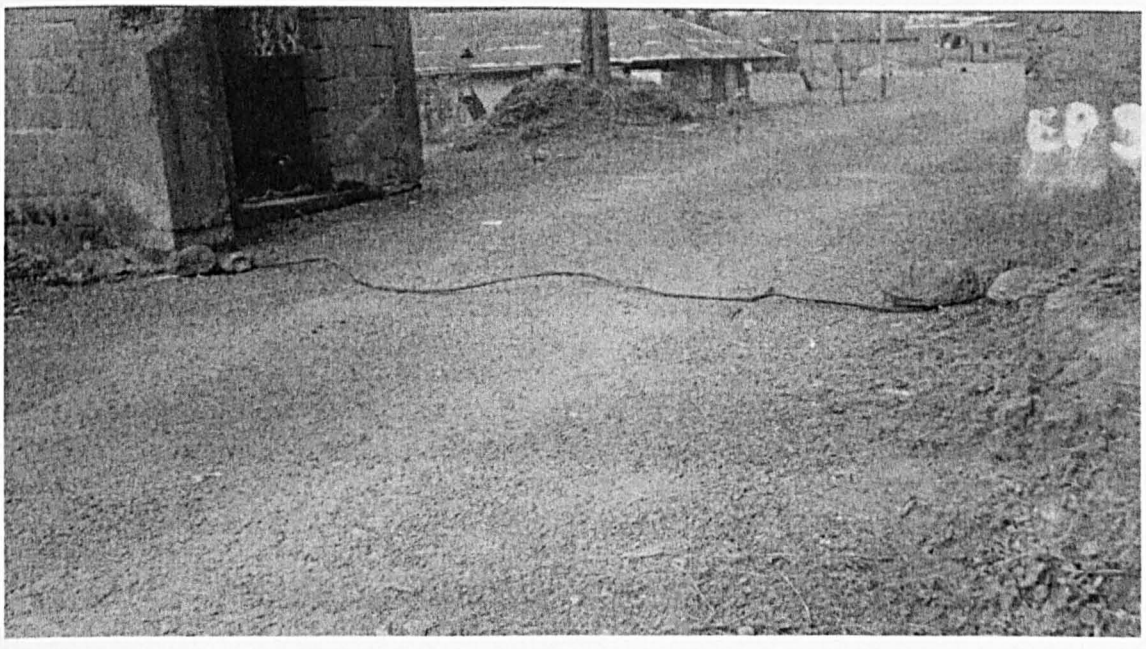

Figure 1: The protective rope lay across the road to protect the entrance to the Bafut Palace

All roads leading to Nsanimunwi, Bujong and the Palace are closed and the circulation of women to these areas is seriously restricted. Young men are positioned at certain places to make sure that women do not move into restricted areas. It is believed that if a woman sees the preparation of the medicine she can become infertile or develop an incurable illness. The *Takumbengs* from all villages assemble at the main shrine outside the palace. They cut, pound and mix all sorts of grasses, sand and water collected from places perceived to be mysterious like lakes, seas, oceans and forest at this plaza. In this case, everybody entering the land has been contained and will not harm the kingdom no matter his strength. A bundle of blessed wood ashes collected from the *Kwifor* lodge is untied and distributed to all participants. In unison, they blow it into the air as a sign of sending away misfortune. Then they disperse to their respective villages with some of the medicines and the same rite is repeated at the village shrines in the village *Nsanis*. The

Mundeughe [protective ropes] are first gathered in the palace where they are specially "medicated" and blessed. After laying the ones in the palace, the *Bukums* [*Kwifor* members] and *Ngangngangs [ritual priest]* are dispatched in all directions with specific instructions to place them at special points. During the *Takumbeng* ritual, the Fon personally leaves the palace in company of some *Bukums* and *Muntohs* [princes] to lay some but his participation ends just around areas closest to the palace.

The next major annual ritualistic activity following the *Takumbeng,* are those surrounding the *Abin-a-Nfor* [The *Fon*'s annual dance] called *M'ma'abumwi* placatory rite. It is conducted just before the *Fon*'s annual dance (*Abin-a-Mfor*), to appease the ancestors so that they should not cause the failure of the dance. It is during this time (the third week of December), that the annual dance is held. Very early in the morning, before the first cockcrow [about 1am], the *Bukums* gather in the palace and prepare the material to be used for the rite. They first start by chanting some ritual songs and bless the gifts of *camwood,* a calabash of palmwine and food in the palace. From then they disperse to different directions, in small groups, to consult and appease the ancestors believed to reside in waterfalls.[27]

[27] According to local beliefs of Bafut people, waterfalls are the lodges of the spirits of deceased kings while those of other important personalities like lineage heads are road junctions. This is why the death cerebration of such people is always crowned in junctions. It is believed that the spirit of Fon Achirimbi II resides in a waterfall on a stream at Mile 21 on the Wum road. Most Bafut people are more familiar with this waterfall than others signifying the lodges of different Fons of Bafut. The waterfalls cults bear the name of the ritual, *M'ma'abumwi*, which means 'worship the ancestors'.

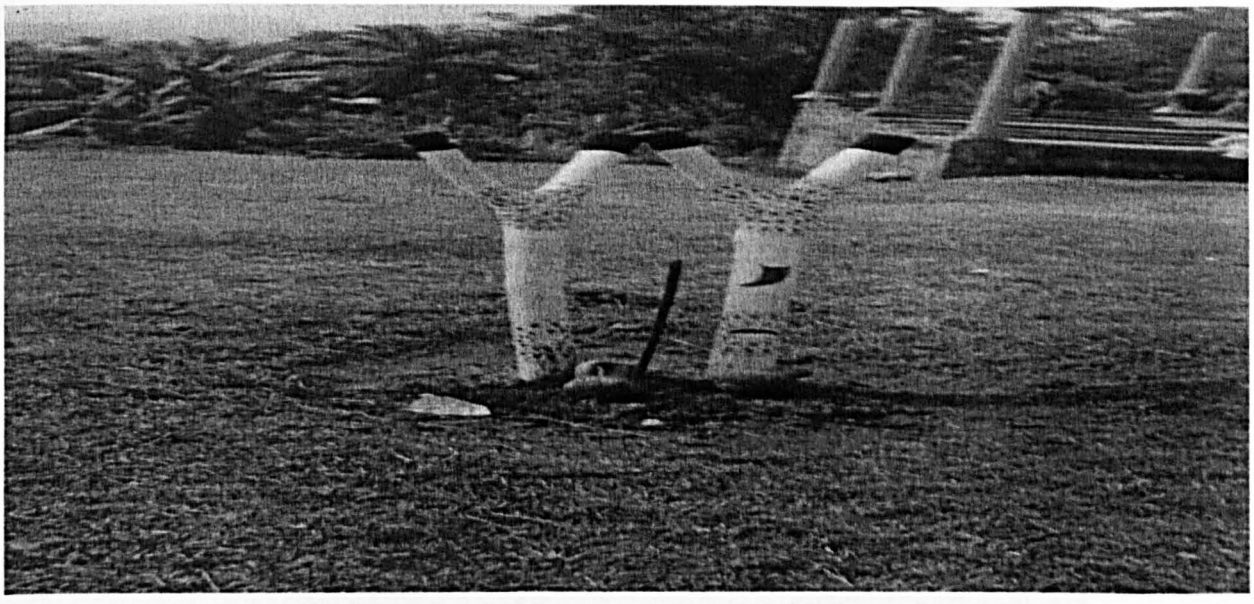

Figure 2: Two pillars where a ram is and buried as sacrifice to Bafut ancestors.

When the *Bukums,* delegated from the palace to appease the deceased *Fons*, reach the waterfalls, they place the food on leaves and put it where the waterfall collects. They also put the *camwood* and a calabash of palmwine nearby. The *Bukums* move some metres away from the waterfall and wait for a while. When it starts raining very heavily, it announces the arrival of the late *Fon* and the ancestors to collect the gifts. It is explained that the heavy rain is restricted to the area of the waterfall and soaks the delegates. During this time, the deceased *Fon* talks to them and sends them with a message to the entire kingdom. When the rain stops, they return to the waterfall to verify if the gifts have been accepted.[28] If the gifts are rejected, they return and inform the palace and no annual dance is held. In this case, the *Fon* (See figure) will send people to different directions in far off Kingdoms like Kom, Mankon, Nkwen and Babanki to consult with fortune-tellers

[28] The gifts are accepted when these emissaries return from their hiding places and find that they are not more there.

and find out why the gifts have been rejected; and what should be done to appease the ancestors. If the gifts are rejected, it is interpreted as an indication for trouble in the following year(s). It means that many people will be sick with incurable diseases and there will be hunger and low fertility. At this period of the year, there is usually heavy dewfall around the morning hours that coincides with the outing of the *Bukums and Ngang-ngangs.* (See figure 3)

Figure 3: The *Bukum* (*Ngang – Ngangs*) going to a waterfall to perform rituals

The sounds produced by the falling dew are taken for rainfall. Whether or not ancestors talk to them is yet to be known, as the *Bukums* are alone at the site of the ritual. The messages they bring back to the palace are a host of symbols which they interpret and explain their meanings to people.

On their return from the waterfall, the remaining gifts are placed on every *Neubah* and waterfall where the spirit of every particular deceased king is believed to reside. The *Bukums* ask for the success of the *Abin* [dance], the success of the next year, the fertility of crops and women, good health and prosperity. When all the emissaries to the different waterfalls return to the palace, the talking drum is played to announce their arrival. The whole environment is quiet to hear the message from the ancestors. In case of success, a black ram is slaughtered at the two "sacred" posts at the dance plaza outside the palace. This ritual is called the *Mbaw-Abin* directly translated as "build the dance ritual". This indicates the official start of the annual dance that lasts for four days. (Figure 4 below presents the *Fon* of Bafut presiding over the *Abin-a-Nfor*).

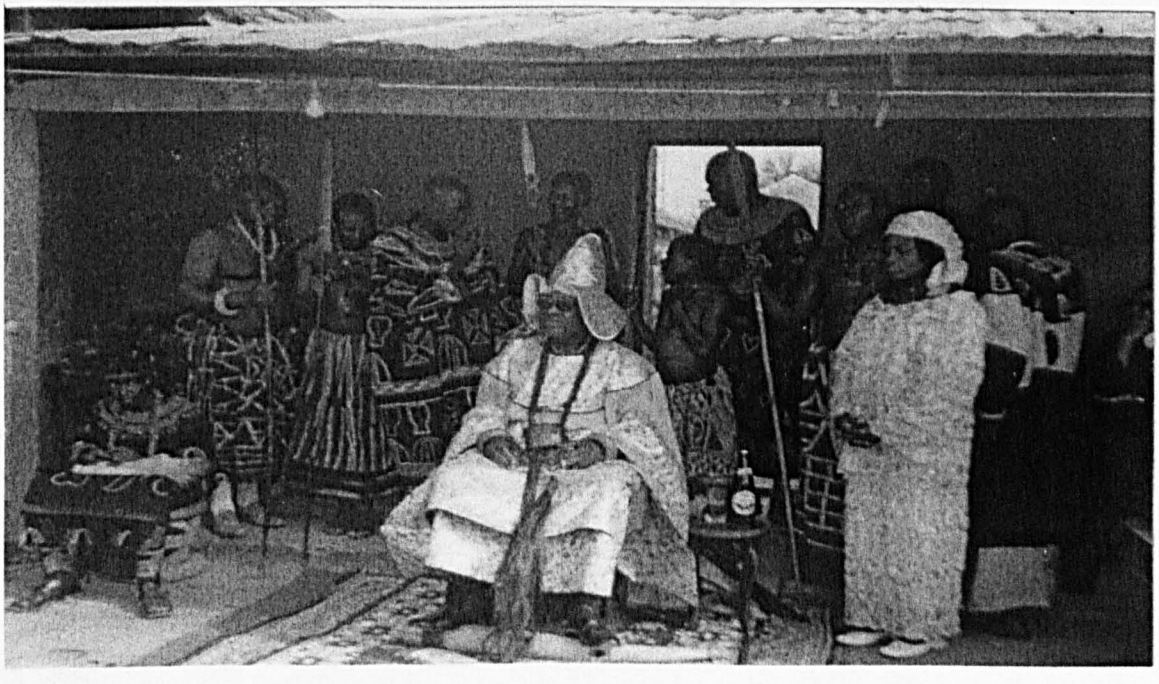

Figure 4: *Fon* of Bafut presiding over the *Abin-a-Nfor* [traditional annual dance]

According to the *Fon*, the year starts in Bafut in the month of February, with a ritual to usher in the New Year. During this ceremony, the Royals visit the shrine of the late *Fon*

Achirimbi II, situated in a waterfall at Mile 21 on the Wum road. The last group of people who go there are the princesses. They return with the offshoots of bananas and plantains, move into the Palace then into the *Achum*[29] (See figure 5) and place them there. It is said that the files of people who go to the waterfall take all the bad things to the ancestors there and return with good health, food and fertility to the kingdom. Those offshoots of bananas signify that they have returned with fortune.

Figure 5: *Achum* [Lodge of the ancestors of Bafut]

Another ritual which is not very regular is that related to the creation of an ordinary new village that entails the performance of some of these rituals at a road junction. According

[29] *Achum* is the main shrine of the Bafut Kingdom situated at the centre of the Palace. It is where the *Fons* are buried.

to Engard (1989), ritual activities to constitute the ward into a sub-chiefdom and to transform the compound of the sub-chief designate are always performed before the formal installation of the *Atangcho* [sub-chief] designate. In the case of Nsem that Engard makes reference to, the rituals have to do with the planting of a monolith (*Neubah*) by *Kwifor* members (*Bukum*) and the building of a *Ndéré* [*Takumbeng*] shrine in *Nsani* [dance plaza]. Princes do this by burying medicine, that is, mixed herbs and specially medicated ropes under the *Neubah* and the *Ndere* respectively (Rowland 1985).

The shrine is similar to that outside the Fon's palace but smaller in size. After the initial rituals, that road junction serves from then henceforth as the *Nsani* [Plaza] of the new village. The biggest and most sacred *Nsani* is that of the Palace. The *Neubah* and *Ndere* planted during the ritual of creation of a new quarter or village are the insignia of independence as well as the umbilical cord linking the village to the palace. The medicines planted under these insignia constitute the spiritual dimension of this link. It is by this insignia that villages are identified (Rowland 1985, Engard 1989; Asombang1999). Quite often, the *Nsani* is not necessarily the geographical centre of the village, but the focus of religious and ceremonial life. For example, during the "cry-die" of an important person like a *Muma* or any other person that requires the public appearance of the *Fon*, it is at the *Nsani* that he sits, receives the family members and performs some rituals to please ancestors. It is at the *Nsani* that family members place baskets of all the varieties of food found in Bafut in appreciation and to come to terms with the ancestors. *Mabuu,* [a *kwifor* messenger], comes and collects his, then people follow in a mad struggle, representing ancestors. This event marks the climax of the death

celebration and jujus can now come out to display on the *Nsani*. It is believed that the late person whose death celebration is being done has brought back the varieties of crops that he was withholding, causing hunger, infertility and ill health. If this is not done, it is possible that a disease [difficult to cure] like diabetes could attack that family and spread from one generation to another.

The next rituals, immediately following that which begins the year, are to launch planting in March; cutting of grass to roof the *Achum* in April and rituals just before harvest in July. There are rituals performed by the *Fon* to install successors, which are held on almost every *country-Sunday* [*Moumetah*]. Besides these main rituals, the *Fon* throughout the year conducts others like 'greetings rituals'[30] concerning status formation and change. However, there are rituals performed exclusively in families, villages and quarters. These are the most immediate rituals performed when one is ill or when some misfortune has to be chased out of the family. There are rituals performed to protect and name twins.

2.4.5 Urban-rural links and family structures

The composite nature of the Bafut people illustrates that Bafut is made up of several clans, all of which are closely knit to each other. The family is basically nuclear and extended building up into sub lineages, lineages, the clan and the kingdom. Interacting with people gives the impression that all Bafut people have royal descent that can be expressed in terms of the near and distant. When birth descent drifts away from the

nuclear family, relationship is patched by folk history and relationship in one way or the other; and also of the movement into Bafut either by marriage or other migratory trends. A family is not confined to the nuclear family of father, mother and children but extends to the lineage, clan and tribe. Though people may have a *Taa*, who is the father of a nuclear family, there is always a senior *Taa* that acts as the lineage head, wielding secret, spiritual, economic and political power over the other *Taas*. A *Taa* is a father for all children and not restricted to those that he has consanguine relationship with but his ritual powers are restricted to his close kin. Similarly, all mothers are called *Nde*. The Bafut family is very extensive and acts to defend its members within the kingdoms. The senior *Taas* are usually *Nzindas*[31] [Successors] who have inherited big compounds and are usually installed by the *Fon* of Bafut. When nominated by the family, the *Nzhinda* is taken to the palace for installation. If a dispute arises, the parties are requested to return home and discuss the matter in the family before returning for another installation ceremony. However, education and the gaining of status have tended to erode some of the elements that create togetherness. Within families common decisions[32] are taken and people respect these structures as the basic cohesive force, no matter the number of generations. While in Nso a *Faay* [Bafut equivalence of *Nzhinda* [Successor] can name a *Sheey* and merely report to the *Fon* (Gohen 1996), that of Bafut must be recognized and installed by the Fon before he can act in his capacity as *Nzhinda*.

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[30] A greeting ritual enables a person to be able to greet and talk directly to the *Fon*. A Bafut man that has not undergone the greeting ritual cannot greet or talk to the *Fon* when he meets him. If he has a problem that needs the intervention of the *Fon*, he cannot personally present it. S/he can spend the whole day and the Fon will never receive him or her. He will always use an intermediary.

[31] A *Nzhinda* that does not receive the symbolic installation by the *Fon* is not recognized by people and cannot pose as one.

[32] Families always have family compounds where family rituals are performed and main decisions concerning the consultation of ancestors take place. It is not everybody in the family that is eligible to be the *Taa* but only one person who is either nominated by the *Taa* before death or appointed by the family using criteria that suit their purpose.

Descent in Bafut is reckoned primarily in patrilineal terms. But people still maintain very strong ties with their matrilineal and matrilateral kin. Monogamy and polygyny are the types of marriage practices. The *Fon* himself has about 60 wives (eight married by himself and the rest inherited from his father (as tradition warrants). The structure of the family reflects the way people live, work and spend. Beginning with the *Fon*, quite a good number of men are polygynous. Polygyny is at times conditioned by the succession system whereby a son inherits all the wives of the father, copulates with them except the mother. This succession means increasing the expenditure responsibility of the family head. Even Christian men, required by the denominational doctrine to be monogamous, at times go in for polygyny or contract marriage regimes that give room for changes to occur subsequently. The men remain Christians after contracting polygynous marriages but are exempted from participating in communion services. Nevertheless, their political and spiritual powers increase and they represent the family in important ceremonies.

The family obligations owed by people living in Bafut, especially the family, lineage, clan heads, including the *Fon*, oblige them to maintain the link with the Bafut people that live in towns. In extreme cases, the *Fon* installs his representatives in the towns, to help him in settling minor disputes that would not necessarily require his intervention. These traditional authorities act as spiritual and political representatives of those living in the towns to protect them from any harm and intervening at the level of the ancestors to ensure their prosperity. At the same time they are viewed as threats to the same people that they protect. Quite often, urban dwellers consult diviners to get explanations for

possible misfortunes and illness, and these diviners would accuse their parents, family heads, lineage heads or ancestors. These accusations may coincide with existing conflicts or guilt, forcing the parties to perform reconciliatory rituals that impel the urban dwellers to visit their villages for that purpose. The collection of ethnographic information has shaped this account of the two districts.

Chapter III

Methodology

3.1 Introduction

Fieldwork for this research lasted over two years. Initially, I did twelve months fieldwork in Biyem-Assi from June 2001 to May 2002. I then spent twelve months in Bafut from May 2002 to May 2003, with two brief breaks, before returning to spend another six weeks in Biyem-Assi from May 2003 to June 2003.

My background training at undergraduate and masters' degree levels was in Sociology. My working experience had been in that capacity, and I was more versed with sociological methods. Although I had been taught ethnography and participant observation as a research method, I had never used them. Now, my main tools were to be a pen, notebooks, a tape recorder and a camera. As a sociologist, I had always trained other people to collect data for whatever 'fieldwork' I had to do. My own contact with people was brief, and I did not know those who provided the data I was analysing. But for this thesis there was no training offered to another person. All my fieldwork depended on me. I had to immerse myself in the business of fieldwork and developed close relationships with those who were to provide my data. This is how I came to understand that people could say something, attribute one meaning today and add more meanings later or change the meanings completely. I too could adjust my aims and objectives and change my emphasis during the course of fieldwork. I understood from my interaction with the participants in the field that fieldwork, in the anthropological tradition, entailed far more than fieldwork in sociological terms. I told myself that ethnographic fieldwork was a film, and I was both one of the actors and an audience; whereas sociological fieldwork was like a photograph taken during an event. I found fieldwork to be highly demanding. But fieldwork opened me up to

many more people and enriched my knowledge of how people lived, what they believed and how they solved problems – not only with diabetes but also with illness generally. A survey would not have provided the depth of the information I have about diabetes as an illness.

This chapter describes how fieldwork was carried out using participant observation. I start by describing how I negotiated access into the two research settings, including the clinics, patients themselves and their families, traditional healers, and Bafut traditional authorities (3.2). I consider 'sampling' in this ethnography, before moving on to reflect on the data gathering process. I then look at data sources and types of data (3.3), and discuss aspects of the social interaction through which my data was collected, including the role of gatekeepers (3.4). Following this, I consider some of the methodological issues raised by doing comparative fieldwork in both a part of the capital city and in a rural area (3.5). I then discuss my own role, as a Cameroonian ethnographer working in my own country, but particularly in Bafut not doing fieldwork 'at home'. As part of this, I explore the ways in which I was seen and some of the language questions raised by working in contexts where several languages were needed (3.6). The last two sections address power relations and ethical issues (3.7 & 3.8). The chapter therefore starts with the most practical issues involved in initiating fieldwork, and ends with more abstract and philosophical questions.

3.2 Access and data gathering

As I mentioned earlier, the choice of Biyem-Assi and Bafut as research settings arose out of the work of Professor Mbanya's ANSA project in these two areas. But before I started fieldwork, I had to obtain authorisation from the Ministry of Scientific and Technical Research. I applied initially for a one year renewable authorisation signed by the Director of Research, to avoid delay as a longer duration authorisation required signing by the Minister. Knowing the Director of Research enabled me to obtain the one year authorisation within a day: I was exempted from bureaucracy on account of my previous relationships. Once I had administrative clearance, I set myself to work making use of the structures set up in Primary Health Care Units. My first step was to contact the clinic authorities in Biyem-Assi in order to get their permission to recruit patients for my study. I followed the same course a year later in Bafut. In Biyem-Assi, I knew the two clinics, which formed the basis for participant observation, from the ANSA project. In my capacity as project manager, I had interacted with staff at both clinics. In Bafut, in addition to the ANSA connection, the doctors were my age mates and had known me while they were in the Medical School in Yaounde, facilitating the initial stages of my fieldwork.

I obtained an ethical clearance from the National Ethical Committee of Cameroon to enable me carry out the study. This added to the authorisation that I obtained from the Ministry of Scientific Research (government authority charged with authorising scientific and technological research in Cameroon). Furthermore, the district medical officers of Biyem-Assi and Bafut and the *Fon* of Bafut gave authorisation and consent

for me to have access to the field. At the level of patients, families and many community participants I also sought consent for their participation.

In Biyem-Assi, I selected particular patients in the clinics where they routinely consulted with a view to following their progress over the course of the year's fieldwork. A nurse introduced me to the patients during a diabetes clinic session as someone who was working on diabetes. Patients were initially told that someone with a special interest in diabetes would be doing research. Their expectation was that they would see me in consultation rooms and in the clinic setting (or in the University Teaching Hospital (CHU), one of the reference hospitals where my office was. I introduced myself in individual conversations by saying: 'I am called Awah, and I'm working on diabetes. I am learning how patients live with diabetes. I would like to observe how you manage with diabetes day by day, and I'd like to talk to you about it. Would you mind if I visit you at home?' Most of the time, patients readily agreed. A number assumed initially that I was a medical doctor – so accepting that I could visit them on a regular basis was also perhaps going to be a benefit or provide some services that were not provided in the clinics. Once contact was made and some trust built up, we would meet at clinic appointments, but also at their homes, or in bars. In due course, as my presence became more familiar, other patients asked me to visit them too, and I decided to pay one or two visits to the homes of those that insisted. These visits were often useful and extended my understanding.

In my previous ANSA experience, it was normal practice in Bafut to announce in church any new research activity or the arrival of a researcher, and to use the occasion to appeal for collaboration. Robert Pool's arrival in Tabenken was announced in local

churches (Pool 1994). I declined this approach however, opting to allow people to 'discover' me for themselves in Bafut. After my time in Biyem-Assi, I was aware that a church announcement might paint an unrealistic picture of whom I was and raise people's expectations. In particular, I did not want to accentuate any more than was inevitable an identity as 'doctor'. In Bafut, I worked with two clinics, but identified most of my patients with the assistance of a male nurse in one of them. The nurse later became one of my main gatekeepers. I made a choice based primarily on patients' accessibility. Moreover, in order to avoid delays during the initial phase, I opted to visit patients in their homes, because clinic activities were not as regular or as organised as those in the two Biyem-Assi clinics. In every instance, I was accompanied, and introduced as a doctor working on non-communicable diseases (NCD). I then explained who I was and my objective to each individual. This 'meeting the patients at home' approach turned out to be very helpful because it introduced me to patients and families at the same time.

It was through patients and their families that I initially gained access to certain community events, and indeed to the wider community. I found this less difficult in Biyem-Assi, because I lived in the city. Even so, there were new things I had to learn – like staying up to all hours in restaurants and bars, if I was to witness properly people's eating and drinking habits. This was not like me. And when people started seeing me regularly in these places, they seemed surprised also. Yet because the nature of community is so different in urban and rural settings, my presence rarely provoked many questions in Biyem-Assi. In Bafut, by contrast, my presence was swiftly known by all and sundry, and people needed to place me. My previous work with the ANSA project was crucial here, and I was helped also by the influence of the

DMO for Bafut. This medical background legitimised me, but was also to prove a constraint later, as I sought to extend my fieldwork and take in the role of traditional healers. Moreover, no one can come to Bafut for an extended stay and fail to legitimise his/her presence by getting the tacit approval of the *Fon* and the wider palace hierarchy, and I was no exception. It was a compulsory step to introduce myself to the *Fon*. One of his step-brothers who worked at the hospital was my usual point of entry when I sought to meet the *Fon* subsequently. But *Muntoh* [Prince Achirimbi] (See figure 6) had always to liaise with one of the Queens to arrange an appointment, making such visits at least a two-step process. This was not necessary when visiting the palace to attend traditional ceremonies open to all – for example, *Moumetaah* [*Country Sunday*]. But whether an intermediary was necessary or not, each visit necessitated bearing a gift. My fieldnotes described my first meeting with the *Fon*.

> 'What can I do for you?'
> *Muntoh* replied, '*Mbee* [a respectful form when meeting the *Fon* as you cannot answer with a straightforward 'yes' or 'no'], this is Dr Awah. He has come from Yaounde. He works with Dr Mbanya in the NCD programme. He has come to greet you and to tell you that he will stay here for one year studying diabetes. He is better placed to inform you about his programme'.
> I introduced myself as follows: '*Mbee*. I am Awah Paschal, a social scientist. I work with Dr Mbanya on the NCD programme. I am a student with the University of Newcastle in England. I shall be staying in Bafut for a year to study how people try to cope with diabetes within their families and in the entire Bafut community. Once in a while I will visit the palace to see how things work here and discuss with you".
> 'You say your name is Awah?'
> '*Mbee*', I replied.
> 'Good! You come from where?' He continued.
> 'From Kom', I replied.
> 'I see. And you bear Awah. Have you checked around to see if you don't have a family in Bafut? That name is Ngemba so might be Bafut. You are welcome to Bafut. You are a Grassfield person, it should not be very strange to you. We shall be available for you to consult at anytime. Make sure that you inform me whenever you need me. I will always help'.
>
> (*Fon* Abumbi II, Bafut 13 May 2002)

Muntoh, shown in figure six below and standing nearest to the rock negotiated many of my contacts with the *Fon*.

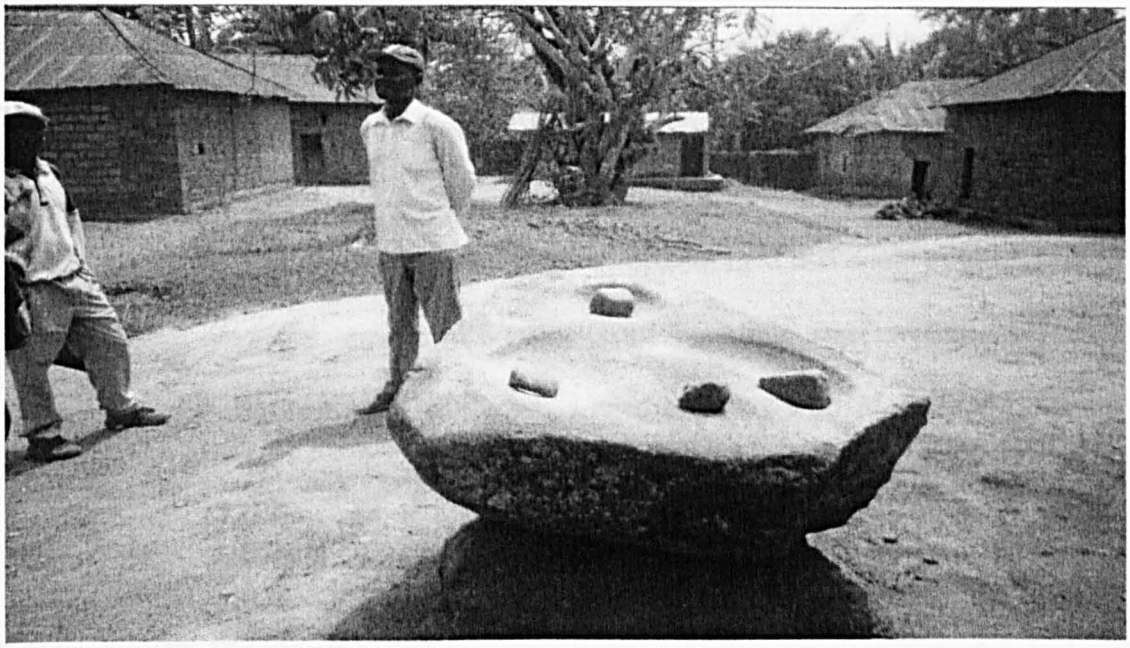

Figure 6: *Muntoh* [Prince Achirimbi]

My initial research plans did not extend to exploring the role of traditional healers in the treatment of diabetes, reflecting the medical frame of reference within which this study was initially designed. But the closer my relationships grew with patients and their families, and indeed with certain nurses, the more apparent it became that such healers were as much part of the picture as were the clinics. However, much senior clinic staff would regret such a suggestion. During the one-year in Biyem-Assi I did not follow up this potential extension to my work. It was only during the second half of my time in Bafut that encouraged by my supervisor, I pursued this line of enquiry, and then did the same during my final spell of brief fieldwork back in Biyem-Assi. It was not hard to make contact with various traditional healers in Biyem-Assi. In fact, a nurse, several years earlier, had told me that science does not explain everything, and that when he was confronted with a problem, he turned to tradition to get the answer.

And he had been the first to mention that traditional healers sometimes attended to patients in hospitals. Once I started making contacts, I found traditional healers were generally open and ready to discuss their work with me. Some acted as intermediaries introducing me to others. Others, indeed, were familiar with researchers and had been interviewed before.

In Bafut, the task was less easy initially. I was discouraged that some might refuse to talk with me, and my unease was accentuated by clinic staff warning me how 'dangerous' and 'mysterious' some were. I need not have worried so much. To my surprise, I developed very close ties with several and we became very friendly. My first opening was with Bobisco [a herbalist] to whom I was introduced by a nurse in a palmwine bar. But though other healers, both in Biyem-Assi and Bafut, opened their 'consulting room' to me, Bobisco never did. Nor would he allow me to take a photo of him, declaring that no image would print because the 'gods' who taught him the knowledge underpinning his traditional medicine had 'hidden' him.

The figure below summarises my negotiation of access.

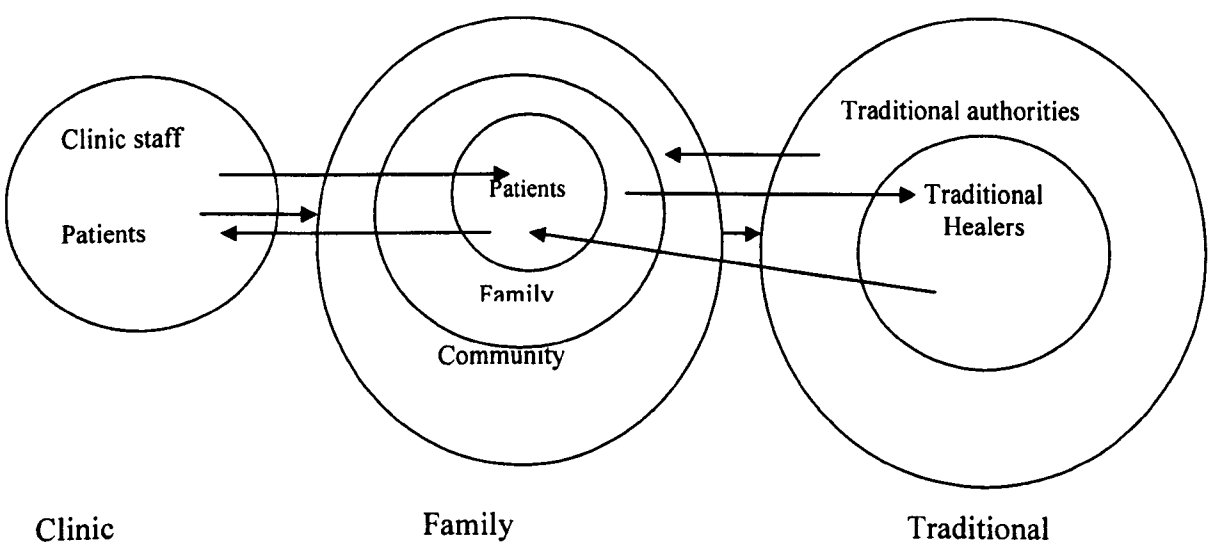

Figure 7: Progress in gaining access in the field.

Sampling is central to sociological surveys (Murphy et al 1998). In ethnography, sampling occurs, but in a radically different frame of reference (Ellen 1984, Hammersley and Atkinson 1990). There are, of course, often reasons why one individual or family is selected and another not. I certainly selected a 'sample' of patients in both settings, though aspirations to select a broad spread of patients inevitably came up against questions of practicality: who was attending, and who was willing to be followed over a period of time. But my minimum aim was to select patients with type 2 diabetes resident in the two places, and who were married, so as to allow for the study of how families, and not only patients themselves, dealt with a diabetic in the household.

'Sampling' in ethnography can be a bit of a misnomer (Ellen 1984, Hammersley and Atkinson 1990, Murphy et al 1998). To say that much ethnographic 'sampling' is opportunistic is to condemn it in the eyes of more quantitative methodologies as unsystematic and unscientific. Yet the reality of daily life for an ethnographer is such that all contacts, all meetings, all events, and all associations are potentially sources of insight and thus data. Because ethnography takes social relationships as its building blocks, ties and connections between people are automatically relevant, whether between 'sampled' individuals or not. In this fashion, my fieldwork extended outwards from the 'sampled' patients and families. For instance, in observing clinics in operation, it would be misleading to suggest that I concentrated on my sampled patients only. I saw this as an opportunity to observe and mix with any and all of those attending. The ethnographer who concentrated on his 'sample' and no-one else would omit much that was relevant. In that sense, the 'sample' most relevant for my study was the initial decision to select Biyem-Assi and Bafut as places to focus upon.

Although patients were selected, this selection, in retrospect, was most useful in providing a way to get started. I cannot say that I 'sampled' clinic staff or traditional healers, for these relationships developed more opportunistically. 'Snowball sampling' is the name sometimes given by sociologists to a widening range of informants. But it is easy to use that term also to legitimate a series of events, contacts and encounters that seem largely due to chance at the time, and in ethnography much is due to chance. The basic point is that the ethnographer should be 'there' in the first place, otherwise no relationships can develop.

Of the two Biyem-Assi clinics I chose, the Etoug-Ebe clinic had the greater number of diabetes patients – 85 at the start of fieldwork and over one hundred by the end. Here, diabetes patients consulted once a month. The Djoungolo clinic had a handful of diabetes patients – a maximum of sixteen – but held weekly clinic sessions. Though these clinic sessions at Djoungolo were more regular than those of the Etoug-Ebe clinic, patients were given monthly appointments for consultations. These were the times I visited, except when I wished to speak to staff outside clinic hours. In Bafut, the small Nsem clinic held consultation sessions every second Thursday of the month; while the district hospital saw diabetes patients every Wednesday and Friday. Unlike the strict timetable operating in Biyem-Assi where patients were expected to turn up during the morning hours on the days set aside for consultations, in Bafut patients attended throughout the day. My fieldwork in the clinics got fitted around these days and times, with afternoons, evenings and weekends being the better times for visiting patients and their families at home.

The element of bias in this study by virtue of working solely with those patients diagnosed previously as diabetic has to be acknowledged. It cannot be completely set aside in this fieldwork given that I was dealing with patients known to diabetes clinics. The undiagnosed (yet to or never to be diagnosed) cases were not part of this fieldwork because they were inevitably unknown to me and other people. But the same would be true of any similar study of people suffering from a chronic disease: it is by definition impossible to define a 'community' of sufferers of an illness, disease or condition of which these individuals are unaware. Most Cameroonians know about their diabetes only through chance events. Others become aware of their status and are lost to any type of follow-up. Hence, about only 20% of people living with diabetes may be diagnosed (Mbanya 1999).

3.3 Data sources and data types

I gathered data by participating as much as possible in the daily lives of the diabetes patients and their families, and in the case of Bafut in the wider community also. I supplemented this by fostering relationships with clinic staff and in the later stages of the research with traditional healers. Fieldwork covers a range of techniques, but I have aimed to relate what people say they do with what they say they ought to do and with what they actually do. For that, conversation and observation are the cornerstones of the study. In both settings, my fieldwork took place over a long enough period that I could be confident that I was witnessing situations which were largely unaffected by my presence. But I must qualify that. The only way to have avoided having any effect altogether might have been to go for a covert study,

something that would have been very hard to justify. Inevitably, my presence did have some effects, and on some occasions my presence undoubtedly prompted certain events. Moreover, I could not always then step completely out of the scene and allow the events to take their course. Accordingly, I have to acknowledge that my presence had some consequences, altogether, and it follows that to varying degrees, I have also been a social actor in the social contexts I describe. As anthropologists (Ellen 1984, Rosaldo 1989, Hammersley and Atkinson 1990, Pool 1994, Gardner 1999, Watson 1999) have readily acknowledged, it is bound to be the case with a methodology that is premised upon our capacity to relate with those whom we study.

More than any other research method, ethnographic fieldwork forces the researcher to live like those he studies (Ellen 1984, Rosaldo 1989, Hammersley and Atkinson 1990, Pool 1994, Watson 1999). For example, in Bafut the staple food is *Achu*, eaten with yellow soup prepared from limestone (commonly called *Kanwa* in Cameroon), oil, and twelve spices collected from the bush or bought from the market. I could hardly visit a home and be served any other food. At the beginning, I took it as an innovation in my eating habits; later its regularity soured. Likewise, even though I do not much like drinking alcohol, especially in bars, I was obliged to if I was to interact with people because most leisure was spent in bars. Moreover, locally produced beers were cheaper and more available, making consumption even less avoidable. The reward was spontaneous behaviour, frank discussions, and a deeper insight into aspects of culture, which I might not have appreciated otherwise. In all this, I tried to be down to earth, and not judgemental.

3.3.1 Observation

Although this was not at all a covert study (Ellen 1984, Hamersley and Alkinson 1990, Murphy et al 1998, Young 1991), certain research activities were partly covert, so as to avoid drawing attention to myself in settings where that would have been distracting to others and unhelpful to my work. Thus, I restricted taking notes in certain circumstances. I generally only took notes where I knew that people would not be suspicious. But over time, note taking became easier – in both settings, but more particularly in Bafut where I was much more visible and likely to be talked about. As I was around for an extended time, people got used to me and knew more about what I was doing. I made sure that I attended Church services, as this was one of the activities that gave people confidence in me. Not only did I attend clinics; in Bafut I participated in the formation of the diabetes association and paid my dues; I belonged to the association of clinic staff; and I attended ceremonies marking birth, baptism, marriage, and death, as well as other ceremonial occasions. The diabetes association went to the extent of informing me about their activities some months after I had left the field. On the whole, I tried to make sure that I was equally attentive to both ordinary and unusual situations, to reflect repetitive and more atypical events (Rosaldo 1989, Young 1991, Murphy et al 1998).

3.3.2 Conversations and interviews

Besides observing, I had numerous conversations. I preferred an informal style of questioning, and my questions were event and case driven, to make an easygoing dialogue possible. Most might be better described as fieldwork conversations (Garfinkel 1967, Garfinkel 1978, Heritage 1984, Rosaldo 1989, Pool 1994, Hutchinson 1996, Gufler 2003), even if the conversation was, in a sense, partly

steered by me. However, I equally refrained from asking questions but simply joined in conversations that people were holding. I could always chip in if I wanted a point clarified or to elicit a response from a particular person. I made sure that the participant's point of view was respected (Hutchinson 1996, Kuwayama 2003, Van Der Geest 2003). With time also, I became more confident in identifying themes and issues in conversations which I was by then aware of as important for my study. It became easier for me to probe into certain topics where I was aware of gaps in my knowledge, or of conflicting viewpoints which I wanted to understand more clearly. In a similar fashion, with time, I also pieced together increasingly detailed biographies of my main informants.

In gatherings, of which, I attended many more in Bafut than in Biyem-Assi, I was nearly always allowed to take photos and record some of the events with a tape recorder. Even so, when I gauged that recording might distract people, I kept the recorder discreetly out of sight, and took to wearing jeans to manage this. I consciously tried to ensure that people did not obviously modify their behaviour (Pool 1994, Hutchinson 1996, Gardner 1999, James 1999, Beatty 1999). However, one day in Bafut, I had a shock when I wanted to take pictures of the *Fon* receiving Peter, the Pastor. A *Nchinda* (palace guard) stopped me. I had thought by then that everyone in the palace knew me and was familiar with my research. Luckily the *Fon* himself intervened; the scene was repeated for me to take the picture.

3.3.3 Focus group discussions (FGD)

Another tool, which I used in data collection in my fieldwork, was the focus group. Focus groups are a form of group discussion that capitalise on communication

between research participants in order to generate data (Kreuger 1988, Morgan 1988, Kitzinger 1995). Although group discussions are often used simply as a quick and convenient way to collect data from several people simultaneously, my focus groups explicitly used group interaction as part of the method of participant observation. This meant that instead of my asking each person to respond to a question in turn as I did with interviews, people were encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on each others' experiences and points of view. The method was useful for exploring people's knowledge and experiences, and was used to examine not only what people think, but also how they think and why they think in a particular way. The focus groups linked to the overall process of continuous data collection, as I sought to make inroads into people' daily lives verifying issues that were raised in focus groups.

The participants in focus groups were purposively selected and the number of participants in focus groups varied from four to eight. I sought to make the sessions relaxed: in a comfortable setting, with refreshments, and sitting round in a circle to establish a good environment. I avoided organising them in hospitals or clinics because that would potentially influence the trend of discussion. Thus I preferred public conference rooms. Sessions lasted from one and a half to two hours but always ended up in social drinking where some of the opinions left out by the more timid participants in the groups gradually emerged. I explained the aim of focus groups to encourage people to talk to each other. But I also adopted an interventionist style, urging discussions to continue beyond the initial questions, and encouraging the group to discuss the inconsistencies both between themselves and within their own thinking. I used disagreements within groups to encourage participants to elucidate their point

of view and to clarify why they thought as they did. I tape recorded and transcribed all focus groups. At the same time I took notes during the sessions, making sure that the social and demographic characteristics of participants were noted. The focus groups were analysed in the same manner as the other methods, as illustrated in 3.3.4 (transcription and analysis).

I decided to use focus groups because they provided a way to help people explore and clarify their views in ways that might be less easily accessible in a one-to-one interview and in conversation. Like interviews, I had to guide discussions using a series of open ended questions and encouraged research participants to explore the issues of importance to them, in their own vocabulary, generating their own questions and pursuing their own priorities. The group dynamics worked well to the extent that participants worked alongside me, generating and taking the themes in new and often unexpected directions. They helped me to tap into the different ways of communication that people use in day to day interaction, including jokes, anecdotes, teasing, and arguing. Gaining access to such variety of communication was useful because people's knowledge and attitudes are not entirely encapsulated in reasoned responses to direct questions. Everyday forms of communication may tell us as much, if not more, about what people know or experience. In this sense focus groups reach the parts that other more formal methods may not reach, revealing dimensions of shared or tacit understanding that often remain untapped by the more formal social science research methods (and fitting in well therefore to the ethos and goals of an ethnographic approach).

Tapping into such interpersonal communication was also important because this highlighted cultural values and group norms that shaped the evolution of my fieldwork. Through analysing the operation of humour, consensus and dissent, and by examining different types of narratives used within the group and through the other methods that I used, I identified shared and common knowledge (Hughes 1993, Murphy et al 1998). Also, focus groups proved to be useful for studying dominant cultural values: for example, exposing influential narratives about lifestyle related to nutrition and overweight, or the ways in which clinic staff coped with treating diabetes patients or dealt with the stresses of patients they viewed as non-compliant.

On the other hand, the handicap of such group dynamics is that the articulation of group norms may well silence individual voices of dissent. Moreover, because the presence of other research participants can also compromise the confidentiality of the research session, this may be a further inhibiting factor. Such interactions highlighted certain aspects of these people's experiences, showing for instance that some participants, especially patients and family members, feared being "punished" by staff for being critical of their practice.

However, it should not be assumed that focus groups are, by definition, inhibiting relative to the supposed privacy of an interview situation, or that focus groups are inappropriate when researching sensitive topics. The opposite may be true, because group work can actively facilitate the discussion of taboo topics since the less inhibited members of the group break the ice for shy ones. For example, when I grouped patients of the same sex and family members together, some members raised issues about sexual dysfunction, a topic of taboo to many, but which in the course of

discussion helped others understand why it occurred and how others handled it in their households. These sensitive topics were followed up in subsequent fieldwork. From focus groups, and as illustrated by my fieldwork, participants can also provide mutual support in expressing feelings that are common to their group but which they consider to deviate from their mainstream culture. In another way, the focus group method also served as a tool to empower my fieldwork participants because they became an active part of the process of analysis, trying to indicate to me things which they forgot and to signpost me to events that I ought to observe thereafter. Indeed, group participants may actually develop particular perspectives as a consequence of talking with other people who have similar experiences.

The group dynamics indeed permitted a shift from personal, self blaming psychological explanations to the exploration of social or structural solutions, whereby participants themselves engaged a certain pattern of behaviour as an outcome of group interactions. Some researchers have also noted that group discussions can generate more critical comments than interviews (Kitzinger 1994). They have revealed that it is a method that facilitates the expression of criticism not only of others but also of oneself. Viewed overall, the exploration of different types of solutions is invaluable if the aim of research is to improve services and one's behaviour.

3.3.4 Transcription and analysis

I transcribed and analysed everything that I recorded from my first day of fieldwork. This was because I could not predetermine the relevant aspects of conversations. I would spend most mornings transcribing and identifying new concepts that emerge in the course of a day. This enabled me to go out to the field with new or follow-up

questions to the previous day's activities. There were moments when it was possible for me to simultaneously take notes and record. These field-notes added to the transcripts rather than replacing them. As there were very few people who could read and write the Bafut language, everything in Bafut was written out and translated by me. If I found any difficulties, I memorised the statement and repeated it to either the nurse or some other person to explain it to me. Later, as I became more familiar with the language, I needed to seek such explanation more rarely. All local remarks presented in this thesis as direct quotations are verbatim extracts from these transcripts. There were about 3000 pages of text from transcripts of observation notes, conversations, interviews and focus group discussions.

These analyses started from the first day that I began fieldwork and continued till I bound this thesis. But it does not mean that this exercise has stopped, because the meanings of things still emerge, whenever I read through a transcript. I was inspired by the ethnomethodology of Harold Garfinkel (Garfinkel 1967, Heritage 1984, Edgar and Sedgwick 2002). Through this analytical approach, I did a continuous conversation analysis of transcripts. These analyses enabled me to develop thick descriptions (Geertz 1973), determine the main themes that emerged at all stages of my fieldwork, and obtain the meanings that are attached to them. Also, I defined (Garfinkel 1967, Heritage 1984, Edgar and Sedgwick 2002) the issues I took for granted and sought to interpret and understand what obtained in the field. The 'thick description' of Clifford Geertz (Geertz 1973, Rosaldo 1989) became my everyday partner, as I tried to describe every event that I came across and sort the meanings inherent in actions and conversations. By so doing, the symbolic values attached to every aspect of daily life were reconstructed and represented with respect to the

participants' lay interpretation, construction and understanding of issues about chronic illness.

3.3.5 Language of fieldwork

During fieldwork, I relied on four languages: English, French, Pidgin and Bafut. The first three of these are languages I have spoken for most of my life. But although I come from the Bamenda Grassfield, the Bafut language was new to me. I started to study Bafut by buying the Bafut Alphabet from the Summer Institute of Linguistics. When I travelled to Bafut for fieldwork, I decided to purchase a book on learning to read and write Bafut and tried to practise it with people. In July 2002, during the summer holidays, I attended a Bafut language course. Most transactions and interactions in public places in Bafut were conducted in Pidgin, even among Bafut people; but at home, in rituals and traditional ceremonies, the Bafut language was used. Moreover, in the clinics the nurses used both Pidgin and Bafut to consult their patients. And during traditional Bafut kingdom ceremonies (such as the *Takumbeng* ritual) or in the palace Bafut was used. In bars, a mixture of Bafut, Pidgin and English was typically spoken. Whenever possible I asked for clarification for anything that I did not understand, ensuring that more than one person explained to me.

In Biyem-Assi, most of my research was carried out in French and English, supplemented by Pidgin. In the clinics where I had most of my clinic encounters, Pidgin was used for consultations and health talks with translations into French. With such ethnic diversity in the city, and the possibility that within a family the parents might speak a mother tongue which their children could barely understand, the use of local languages did not arise. My own interviews or conversations were largely done

in English or French, while in the case of traditional healers, Pidgin tended to be more useful. Transcripts and notes taken in other languages were translated into English.

3.4 Social interaction

While I sought to mix widely in both settings, like anthropologists everywhere, I found myself at moments dependent on gatekeepers (Rosaldo 1989, Pool 1995, Hutchinson 1996, Gufler 2003) who facilitated, but also influenced the access I sought to individuals, groups or specific settings. Some gatekeepers I could choose; others simply emerged largely by chance (or so it seemed). They featured in both Biyem-Assi and Bafut, but much more obviously in the latter, where entry to the palace depended on formalised gatekeepers in a way not apparent elsewhere. I have already referred to the way in which, via a Prince and then a Queen, an audience might be obtained with the *Fon*. In both places, clinic staff performed a gatekeeping function in helping me to meet patients. Further, initial progress in seeking to establish social relationships with traditional healers depended on the introductions and reassurance (for both of us) that a gatekeeper could provide.

In Bafut, this process proved more difficult than I had expected. I asked one particular key informant (a nurse) if he could arrange a meeting. Two weeks went by before he made any effort. When he returned, he told me that some money would be required before any meeting was possible. I decided to try a different tact, and with the

assistance of *Muntoh*[1], I made contacts with one traditional healer, who allowed me to observe him in practice. That gave me the courage to try and meet others.

When I recounted my experience of meeting the first traditional healer to the nurse, he offered to take me to Alhadji, another traditional healer. I would have gone alone but on my first attempt to meet him, the compound looked frightening. I saw a knife nailed on the floor and another to the ground directly at the entrance and two spears crossing the doorpost. Worse still, the door was wide open without a person around. When I managed to make my way out of his fence, I decided to seek the nurse's company. Later, when I met Alhadji, I discovered that we knew of each other but had never had an opportunity to talk to each other. Alhadji told me how he had made efforts to talk with me but a good opportunity had not arisen. He supported the impression I had that nurses were reluctant to put me in contact with other traditional healers because the nurses feared and respected traditional healers and also considered that these healers may bewitch me; that is; use their powers against me. Since nurses were the first group of people with whom I interacted in the community, their feelings were obviously expressions of concern for my security more so because they did not understand the processes involved in anthropological fieldwork.

In Yaounde I used other traditional healers as gatekeepers to contact others [snowball approach]. But this type of collaboration was completely absent in Bafut. In other cases I turned up where I saw a signpost indicating the presence of a traditional healer and introduced myself. You could hardly hear a traditional healer talking about another. If he did, it was to condemn his practice. It was a life of competition, hatred

[1] Muntoh means Prince in Bafut language.

and secrecy. Many anthropologists who have worked in the Grassfield like Robert Pool (Pool 1994) used assistants. I did not find that necessary but resorted to making use of the gatekeepers in the field. Pool (1994) had at one stage in the field started having misunderstanding with his assistant because people did not want his presence around any more especially as he did not come from that village. If I were to have an assistant in Bafut, it would have been the nurse, but I would have run into problems because he comes from a part of Bafut that challenges the authority of the Palace. The nurse had at one time been a target of political problems linked to the palace and so had to escape being beaten. He could not take me to certain places because people were suspicious of him.

There was no problem in using clinic staff as gatekeepers to meet patients. In fact, they served as the best way for me to have first contacts with the patients at the clinics. But using them to meet traditional healers and authorities was the most difficult thing that I found. I decided to approach them myself. At one time, I felt that the nurse had become inquisitive and wanted to know what I was doing with all the information that I was collecting. I decided to reveal some to him so that it should not be a barrier for him to be open to me. In August 2002, I received a visitor from England and accompanied him to Yaounde. Before departure, I left one of my transcripts and fieldnotes on my table, then locked up the audiocassettes and the rest of the fieldnotes and transcripts in a drawer. I handed my door keys and recorder to the nurse assuming that he will try to search my home to read what I write. On my return, there was evidence that he took time off to read the transcripts and fieldnotes. He was asking me questions from issues found in my notes and always reminded me to take my field equipment when I was visiting with him. He had taken one of the

unused audiocassettes and went taping interviews with his patients in the clinic. He brandished the cassette and told me that he had good material for me. I congratulated him and that earned him more drinking sprees. In the taped audio conversation recorded by the nurse, patients gave him the impression that they approved of his performance, whereas they had been critical of him when talking to me. Of course, the patients could not say anything negative about him to him for fear of facing unfair reception. His action was not absurd but served as a way for me to understand how patients may hide their real feelings about him and the clinic.

It is always good to use gatekeepers as springboards for the first encounters but it is better to gradually detach from them and establish a network of relationship with research participants. Gatekeepers become constraining as their value may get exhausted as the research develops. Each of them has a vital role to play at a given place and time given that some doors, which are open to you, are closed to them.

3.5 Comparison between doing fieldwork in Yaounde and Bafut

One of the first things I had to do was to understand the differences in the languages used in both Biyem-Assi and Bafut. Doing fieldwork in Bafut required that I should be able to understand and speak some Bafut as well as Pidgin English. My range of languages (French, English and Pidgin) was sufficient in Biyem-Assi.

Fieldwork in Bafut was relatively easier and more involving than in Biyem-Assi. In Bafut I could predict when to meet people at home or in a ceremony but this was

difficult in Biyem-Assi. People in Biyem-Assi were very mobile and I visited families when they had travelled. Fieldwork in Bafut was all round the clock. There were no moments of rest. Even when I was sleeping I was very alert to pick up every human and instrumental sound outside because most of the sounds had a ritual connection, which entailed provoking incurable diseases if one did not respect the tradition that goes with it. I always woke up to peep through my blinds to see what was happening and the next day I asked people what the noise was for. There were moments when I had to sleep late or not at all because I had to attend a death celebration or wake keeping. At times, I got up very early because a message from the palace needed people's attention or because a traditional rite was being performed and people were requested to restrict their movement. The ethnography in Bafut was richer than that of Biyem-Assi. It was easier creating contacts with people in the Bafut community than in Biyem-Assi (See figure 8). For example, it took me longer to meet the DMO of Biyem-Assi because he was always out of the office even after an appointment had been booked. But it took me just an hour to be able to set things up with the DMO of Bafut. People in Bafut were ready to offer their services to me and provided me with information. However, there were always expectations. They expected as a result, to be bought a drink in a bar and this was considered a sign of creating some close friendship with me. It was a matter of always being there (Pool 1994, Hutchinson 1996, Watson 1999, Gufler 2003), getting to know what and how (it) was happening and why.

Figure 8 below shows children racing towards my home to present a trophy they had won in a Church competition. Children were part of those I interacted with, in order to reach out to their families and the communities.

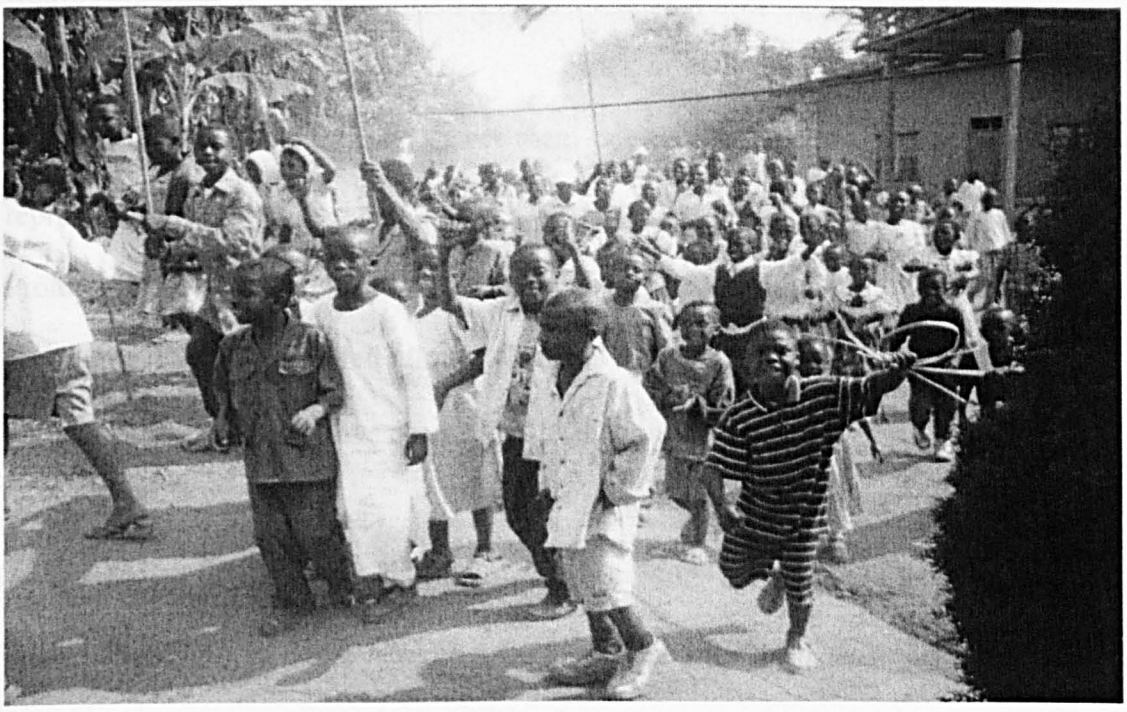

Figure 8: Children of the Presbyterian Church Manji dance towards my home to present a trophy to me

However, when I had a breakthrough with informants and places without further questions, they became very concerned about what I was doing and always offered food and drink or one of them whenever I visited them in their homes. Whenever I refused, people interpreted that as a sign of discrimination against them. I had to accept the offers most of the time to avoid being rejected but made sure I made a counter offer. Another thing that I may say helped me was the idea that I encouraged patients to form diabetes associations. This interaction enabled us to work together and also to build confidence amongst patients and their families especially in Biyem-Assi, where the patients were more distantly dispersed. It created a forum where we

met for five months to work on their constitution. During this time, I moved closer to many of the patients and the families. That gave me an opportunity to keep an eye on all they were doing. It gave me ready access to their families, as some knew that we were all members of the same association and I was, in addition, doing research that would help them.

In Bafut, I went an extra mile to get them one-touch glucometers from a Lifescan representative to use for the World Diabetes Day [14 November 2002] through Professor Mbanya. After that day, I received lots of invitations to this or that ceremony. This also entailed a lot of financial implications, as I had to go with gifts, but this permitted me to have access to information.

At the advent of the dry season, in November 2002, the ritual cycle (Engard 1989, Asombang 1999) in Bafut reached a turning point with the *Takumbeng* and *Abin-a-Nfor* [annual dance rituals]. People did not restrict me to moving to junctions where these medicines were being prepared as male Bafut people were allowed access, but I was not allowed to take pictures. Towards the last two months of fieldwork, people in Bafut thought that I was helpful and living a very good life with them so merited a traditional title. My abrupt departure at the end of my stay, because of my son's ill health, called off the issue. And just as my experience of participant observation spilt over from Biyem-Assi to Bafut, helping me to improve considerably in my approach, so the Bafut experience was very helpful to me when I returned to Biyem-Assi to complete 6 additional weeks of fieldwork.

3.6 Insider and outsider – home anthropologist

3.6.1 Doing anthropology at home

Here, I give a self-scrutiny on my position in this fieldwork; examining the pros and cons of doing it in my own country (Hadolt 1998, Fainzang 1998, Reis 1998, Van Dogan and Fainzang 1998, Gardner 1999, Watson 1999) and in these two sites. The advantage I had doing this fieldwork in my country was that I knew where to go for the clearance and I had my arrangements go through easily. I knew a good number of gatekeepers at the onset of my research. My knowledge of the four languages used in carrying out daily business in Cameroon was an additional advantage to me.

The disadvantage I had was that I had family responsibilities to tackle while I was in my country. When I was in Yaounde, I could take a day or two off to handle issues concerning my family. If I were away, other people would have been more concerned with this. Also, I exerted some influence as my research subjects had a lot of expectations from me. I tried to satisfy some of them, because this could have affected my fieldwork. In such cases, I avoided direct discussion of the problem and the research subjects got the solutions by themselves using the advice that I gave. When I went to Bafut, I had a taste of staying away from home and doing fieldwork. There was no family to cater for so I had to meet new people and negotiate how to live with them. In Biyem-Assi, I needed to restrict my staying away from home because of the threat of crime but in Bafut many people stay out of their homes to any hour of the night without nursing any fear of being attacked by robbers. This permitted me to stay out for as long as people could stay awake. These changes in lifestyle also introduced

me into more drinking than had been adopted during fieldwork in Biyem-Assi. But this gave me more material to work on.

Doing ethnography as a Cameroonian in Cameroon meant that I already had a notion about certain things (Young 1991, Pool 1994, Pierano 1998, Gardner 1999, Kuwanyama 2003) like being proficient in languages widely spoken in the settings and in the administrative procedures. Some foreign fieldworkers have visited Cameroon more than once to get issues of administrative clearance done before they could start fieldwork. I knew some of the key people in authority so I did not suffer delay. Another Cameroonian, not knowing these channels, would have had things done for him normally but not with similar speed. In the field in Bafut, my name, (Awah), served as a significant integrating device as people first identified me as possibly being Bafut or a sister tribe around until I clarified that I was Kom.

This does not mean that I was doing fieldwork in my community; far from that. I was regarded in Bafut as a stranger (Pool 1994, Hutchinson 1996, Van Dongan 1998). Most of the rituals conducted here were completely new and strange to me. Even Bafut people who had stayed in Kom used to say, "In Kom, this is the way it is done. In Bafut this is how we do it". I had to learn very new and strange behaviours that I had never come across. Talking about fieldwork experience, Ellen (1984) holds that doing research in one's country is equivalent to doing research at one's home or in one's community (Hadolt 1998, Fainzang 1998, Peirano 1998, Reis 1998, Van Dogan and Fainzang 1998). This is not quite obvious with me. In both Biyem-Assi and Bafut, I was a stranger to the land and people. I was called, *Ntobo* [stranger] by the Ewondo in Yaounde and in Bafut, *Mou-Kom* [the child of Kom] all meaning

'stranger'.[2] So, ways of life were different and each of them had its own interpretation to issues. The global way of doing things and the mixing of cultures has created lots of resemblance in behaviour and the interpretation of things. For example, one of the main cults [*Chong*[3]] in the Bafut palace never used to exist in Bafut until it was brought from the Aghem Kingdom by a girlfriend of one of the princes.

But, a country in the African context is quite different from a country in the Western context, given that what obtains as 'country' in the West is equated with a tribe or ethnic group in Africa. For example, the notion of the head of a clan/tribe is understood as being a 'King' in his own right. The boundaries between countries, drawn by colonial powers do not necessarily pull together the different cultural traits to make people be regarded as strangers in the same way as in the West.

However, I tended to grow sympathetic at certain times when I encountered a sad situation. I tried to suggest ways to help solve some critical problems of which I was part. This in a way could modify a certain pattern of behaviour that someone would have adopted if s/he faced a difficulty. A foreign fieldworker would have merely gone about his/her business and allowed the situation to take its natural course. A good example is that of a patient, who was going to spend two months without receiving insulin because the family could not provide. They complained to me and I bought her the insulin that she took for two months. However, if I did so it was because subjects always had expectations from me as I interacted with them. It shows that fieldwork is an exercise of exchange between a fieldworker and the participants.

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[2] In Ewondo, "Ntobo" is a settler meaning stranger and in Bafut language *Mou* is child and Kom is the Kom Kingdom. This means the child of a Kom man.

[3] The Kom people have a *Chong* which is a society of elderly and titled men completely different from that of Bafut which is an association of princes.

3.6.2 The strange scientist-doctor

Here I examine what it is like doing ethnography in a culture that understands health research to be fundamental scientific research. Was I seen as a rather strange kind of scientist? With my background training being Sociology, how difficult was it for me to switch over and embrace the demands of participant observation?

Clinic staff initially had the impression that I was a medical doctor and one day they referred Queen Christina [the *Fon*'s wife] to me when no doctor was present in the hospital. When she came to my home, I took time to explain what I was doing to her and moved out to search for a doctor to attend to her. This was embarrassing and could have cost me my stay in Bafut had there been any confusion about my role. From that day, she always found time to explain issues about Bafut culture to me whenever we met. Since I did not consult like the two medical doctors of the district hospital, people referred to me as the doctor in charge and specialised in NCDs only. Three months later in my fieldwork, people found out that I was more interested in diabetes patients and their families so they gave me the title of 'diabetes doctor'. To them, I was the boss of the two medical doctors in that disease. But when I became very interested in the traditional medical practices and was frequenting traditional healing homes, people were confused and considered it to be strange.

In the two sites, people thought that I might be trying to study what the traditional healers use in curing diabetes so that those leaves could be refined and used in the hospital. In other words, they assumed my work must have a scientific purpose, and be aimed at 'discovery' of new treatments. To people, it was a good idea to find someone studying these medicines that may provide a cure. People questioned why I

was very close and down to earth with the people in the community and the medical doctors were not. They appreciated my openness and were always eager to guide me to where I could get information.

Doing ethnography in a culture that understands health research to be scientific research looked very challenging to me. Initially, people thought I was going to stay in the laboratory on a microscope or be consulting patients. The most they saw me do in the clinic was to sit in when consultations were going on and watch patient consultations, take notes and ask questions to the staff and some patients. If I shared a seat with patients who could read and write, they always peeped into my notebook to figure out what I was writing. When they discovered that I was just taking an account of what was being said they went about their business. Initially this looked strange to the patients but they later came to understand that I was writing notes for myself, and that had no repercussions in their lives. The patients kept attributing different roles to me just as happened with Pool (1994). Initially, I was viewed as a medical doctor but when they never saw me consulting as clinic staff did, they changed the appellation. It did not take long for patients in Biyem-Assi to understand my role. In Bafut it was a gradual process.

3.7 Local power relations in this ethnography

Below, I discuss the negotiation of power relations in the field showing the context which I was seen as of higher status than those I mixed with and the context where I

was not very powerful. I also reflect on how local power relations shaped my access and the perspectives that I present.

Power relations in the field are mixed and must be negotiated as circumstances permit (Rosaldo 1989, Young 1991, Goheen 1996). They are not permanent in so far as exchanges takes place which may alter perspectives on either side. I did not have equal status with every person in the field. There were some participants who had higher statuses so I had to beg for any relationship. For example, whenever I had to visit the *Fon* of Bafut, I needed to make an appointment and use a gatekeeper at two different levels before I could reach him. I could chat with him within limits for he had the powers to allow me do fieldwork or reject my request. Once he was available, I maximised the time that I had to spend with him. Whenever I met him in public I watched and listened to him very closely because it was difficult seeing him again. Other people of very high statuses were the Director of Research and all the district medical officers (DMO). They had authority that could stop whatever I was doing in the field but I had long-standing relationships with them to the extent that they were always ready to assist me in times of need. I decided to keep very warm relationships to make sure that my stay in the field remained hitch-free. Generally, I did not have an inferior status with most patients, as they knew that I was doing research on their diabetes and this could lead to improving the quality of care given them. They valued my presence amongst them. High profile patients like Martin and Maureen in Yaounde and Samuel at Bafut, whom I thought could be less receptive because of their positions in society, turned out to be closest to me.

I had been given the impression that traditional healers were the most difficult people to approach and deal with because of their superior positions in society but experience proved that they were the most collaborative. Whenever I approached them for the first time, fear and anxiety surrounded me but the reception they gave me was friendlier than other people imagined it might be. Instead, they regarded me as a high profile person comparable to the medical doctors around. The expectation was that since I was dealing with them and the medical doctors, I could be a possible link between them and the medical doctors. They turned out to be the most easily accessible group.

3.8 Concluding discussion on fieldwork

My fieldwork is the type that Anthropologists describe as doing fieldwork 'at home' (Pool 1995, Hadolt 1998, Fainzang 1998, Peirano 1998, Reis 1998, Van Dogan and Fainzang 1998). It is the type that portrays me as both an 'insider' and an 'outsider' (Young 1991). What is important is what I did, how I did it, whether I did it according to anthropological tradition and the end product. I was an 'insider' as a Cameroonian working in Yaounde, where I lived, and in Bafut, one of the Grassfield Kingdoms with which my own cultural area by birth had much in common. But I was an 'outsider' as a social scientist (Young 1991) enquiring into indigenous medical conceptions and also an 'outsider' in the places where fieldwork was conducted by virtue of my birth and cultural identity. Most clinic staff who knew my social position considered me as an 'outsider'. Others who initially considered me as an 'insider' changed their idea as they subsequently understood what I was doing. I was a stranger

in this land and had to negotiate access like anyone who had no previous links there. The way I presented myself, the role that I played and my interaction with people, contributed greatly in the field. Even though objectivity is never total, sympathising with people is an aspect that an anthropologist can risk undermining if he goes completely native, forgetting to apply anthropological principles.

I used participant observation in conducting fieldwork, which entailed studying the urban and the rural. Once, anthropology was associated with study of 'primitive' societies. A study like mine studying both a rural and a part of the capital, contributes to the rethinking that has been going on in anthropology for many years about the nature of the discipline today. The neglect of studying urban phenomena is gradually being broken and my looking at the two environments lends credit to this work as another step towards comparatively analysing the complex order of the urban and rural societies.

I have put into practice the challenge that faces the conduct of ethnographic fieldwork in urban settings comparing with the rural. My experience can be improved on in subsequent comparative rural/urban fieldwork. I did not set out to do fieldwork differently in the 1.5 million inhabitants of Yaounde or the more than 400 000 inhabitants of Biyem-Assi. The intensity of the fieldwork might have differed but I tried to use the same approach in both the urban and rural health districts. It happened that my choice of a rural health district (Bafut) was one where the population is relatively very homogenous, hence this permitted me to study issues of ritual life and interact more in a wider community than was the case in the urban health district of

Biyem-Assi in Yaounde. I chose Bafut and Biyem-Assi because these were the only two health care districts that provided Primary Health Care (PHC) to diabetes patients.

A greater majority of the residents of cities come from some rural area and bring their cultures into the city. Culture is a continuous umbilical cord that links urbanites to their villages or tribes. When these cultures meet in town, they undergo transformations and new cultures emerge, for example amongst socio-professional and ethnic groups. At the same time, urban characteristics are spilling over into rural areas. My urban and rural comparative approach portrays the beliefs, understanding and behaviours that people in urban and rural areas have and share about diabetes. These might not necessarily show a clear demarcation from a bird's eye-view, but closer attention shows that culture in the context of diabetes carries a lot of meaning with it. I did not focus on any specific ethnic group to study diabetes in urban areas or in Bafut but selected diabetes patients receiving care in the four facilities that were offering PHC and their families. If anthropological fieldwork does not step aside and reinforce urban ethnography, some of the problems of urban areas will be less understood and will remain unresolved. A health issue like diabetes cuts across cultures and needs to be understood from both rural and urban perspectives so that solutions to the illness and other chronic diseases can be more broad-based.

Although I am a Cameroonian and a grassfield person, over the years I have become simultaneously of another place as well, a child of anthropology. This combination of birthrights has produced an interesting complexity that the less observant might mistake for a dilemma. My complex status enables me to take a distant middle position to gain access, study, understand and interpret this ethnography as an insider

and outsider using 'strange' scientific approaches with which people could not identify. These complex positions and roles provide a more complex comparative ethnography than a completely foreign or even a completely native person. However, I keep the anthropological tradition intact, respecting the privacy and voices of the people who produced this knowledge (Rosaldo 1989, Pool 1994, Goheen 1996, Gufler 2003).

In the study, I was always tempted to draw on assumptions and comparisons with what I knew about my own ethnic culture, which most of the time turned out to be contrastingly different. Doing my ethnographic work in my home country was a privilege which did not bring about a subjective stance but, on the contrary, made me better able to probe more deeply into what could otherwise seem obvious and so go beyond what a foreign observer could explore.

Most ethnographic studies in Sub-Sahara Africa have been rural based (Kaberry 1952, Nkwi 1979, Rowlands and Warnier 1988, Engard 1989, Pool 1994, Goheen 1996,) with very few urban ones (Sanjek 1990) but mine has considered the two settings. This comparative approach, even though very challenging is actually the most rewarding because of the amount of ethnography that it produced, ushering in a new perspective.

I end this chapter with a note on issues of etiquette of ethnographic writing, especially, concerning pseudonyms (Ellen 1984, Pool 1994, Rowlands 1995, Goheen 1996, Ryan 1998, Gufler 2003, Kuwayama 2003, Van der Geest 2003). I have given an identifier to each group of actors. After consenting with patients, I have used their

first names when talking about them because they requested to be identified in my work. Amongst the family members, I decided to identify one only, because he pleaded for that to be done, for him to have pride in being seen and read about. Like patients, traditional healers requested that their real identities be revealed so that it can serve as their personal archives. Clinic staff have been named by their titles; for example, nurse and doctor. When writing about private individuals, I used pseudonyms to protect their identities and privacy, taking liberty with ethnographic facts, in order to disguise identities, doing all I can to retain contexts and arguments. Highly ranked personalities like the *Fon*, have been addressed by their titles and names. Why did I reveal the identities of some informants and not those of others? I explored many possibilities for handling this problem. Drawing inspiration from the works of other ethnographers (Ellen 1984, Pool 1994, Rowlands 1995, Goheen 1996, Gufler 2003, Kuwayama 2003, Van der Geest 2003) and my personal experience, it occurred to me that I should combine various approaches in order to satisfy the range of different actors. For some it was going to be famous to be read about and for others, like nurses, I thought it was important to conceal their identities, especially linking them with their actions. One underlying issue here is that ethical issues, though universal, seem to be context based because a serious ethical issue in western countries may not receive the same weighting in many African settings, so may therefore be handled differently.

The issue of anonymity, or the protection of the confidentiality of data acquired through fieldwork, is nowadays one of major importance in all the social sciences. We must recognise, however, that there is no single model of appropriate respect to the sensitivities of the individuals concerned in a study like this. The issue needs placing

in context. What I mean is that in Africa published personal biographies and written archives are few, and many people would be proud and happy to find works written and read widely by others about them. These works serve as archives for several generations, who may not have had the opportunity to see anything written about their predecessors. For that reason, people accept much more readily than in, say, modern Britain the thought of being identified in research.

Being named is being acknowledged, which for many is less offensive to their lives and that could serve as part of a kind of national archive of personal biography. Again, the wide beliefs in ancestors facilitate this, as people think these are the main sources by which their presence and role will be acknowledged and recognised even when they are dead. Van der Geest (2003) during his first fieldwork in Ghana decided to hide the identity of his subjects. But he was later blamed for doing that by the subjects of his fieldwork, who felt themselves to have been effectively silenced and disregarded. When he did a second spell of fieldwork he decided to use people's names to identify individuals fully in his publications. Robert Pool (1994) and Gufler (2003) also revealed the identities of many of their informants by using their names and picture illustrations. This, in a way, confirms my opinion that at least some ethical issues seem to be context based. In my case I sought the consent of all participants whose names I have revealed and whose pictures I have presented in this thesis. Others requested to have them included in my book when it is published, and others accepted their names being revealed but did not want their pictures published. Thus I hope to have shown how I have been sensitive to the cultural preferences and sensitivities of those who have been the subjects of my research.

Chapter IV – Literature Review

4.1 Introduction

In this chapter I shall review some of the literature relevant to my subject. As a thesis in the tradition of medical anthropology, I have found that my study has no precise parallels in other ethnographic work on the management and treatment of diabetes in West Africa, let alone Cameroon itself. In that sense my study is a first. However, my work is able to draw on a certain amount of literature on the epidemiology and public health aspects of diabetes in the context of sub-Saharan Africa, on the one hand, and a considerable anthropological literature on aspects of West and Central African society and social experience, on the other. Two strands of the latter are particularly relevant in this context: first, extensive ethnographic writing on health, medicine and beliefs about healing and the nature of disease; and second, writing on Bafut itself, and more broadly the surrounding Grassfields region, which proves to be an unusually well-documented area, with work dating from colonial anthropology to the present. My work has therefore benefited greatly from these earlier works. This chapter highlights a number of key themes in this literature. Given that this is a work of medical anthropology, I have given a relatively little space to the epidemiological and public health literature, and discuss it at the beginning of this chapter. My greater emphasis is on the social and more precisely anthropological literature.

In consequence, the next section (4.2) focuses on the epidemiology of diabetes in Sub-Sahara Africa and some family-based interventions. Then I move from a public health focus to a social one and discuss the medical anthropology in sub-Saharan Africa, with special reference to West and Central Africa (4.3). Following that, I discuss the more general ethnographic literature on Cameroon (4.4) in which I overview the

historical background (4.4.1), consider the absence of ethnography in Yaounde specifically (4.4.2), before turning to the ethnography of the Grassfield and Bafut (4.4.3). A concluding note on the literature review (4.5) ends this chapter.

Before discussing the literature in greater detail, I would highlight a handful of key works. On the anthropological side, four works have been of special ethnographic significance. All relate to the Grassfield. *Women of the Grassfield*, by Phyllis Kaberry (1952), was a landmark study in its time in its concentration on women's social experience. Its recent reissue testifies to its continuing importance. Along with her colleague Elizabeth Chilver, she was the doyenne of Cameroon ethnography, writing during the later part of the colonial era and in the British-ruled part of Cameroon. More recently, Miriam Goheen's *Men own the fields, women own the crops* (1996) has been another landmark publication, based on fieldwork over many years in the same part of the Grassfield as Kaberry's study, in a sense updating the earlier work, but also bringing a political economy perspective to bear on gender. Quite different has been Hermann Gufler's *Affliction and moral order: conversations in Yambaland* (2003). The work of a Catholic priest turned anthropologist, who has lived in Yambaland for many years, it explores with enormous detail both the ritual practices of the area he knows and the beliefs or understandings that underpin. He thus approaches matters of health and illness by way of an interest in ritual, and the ways in which misfortune or affliction is dealt with through ritual. My fourth example is in some ways the closest parallel to my own study: Robert Pool's *Dialogue and the interpretation of illness* (1994). A self-consciously experimental ethnography, influenced by postmodernism, this book focused – as my study does – on a single disease, in his case kwashiorkor. Pool seeks to understand not simply how people

handle this disease, but seeks to understand how they categorise illnesses or diseases which encompass what biomedicine labels 'kwashiorkor' building up his account in terms of the idioms which local people use in everyday life. There is one further work, which deserves to be mentioned alongside these. The key text on the epidemiology and public health challenge of diabetes: *Diabetes in Africa* (Gill et al 1997) examines how the epidemiological transition taking place in Africa has significance for the recognition, incidence, prevalence and treatment of diabetes.

4.2 Diabetes in sub-Saharan Africa

This section presents the definition and implications of diabetes, examines some of the works that have been done on the prevalence and epidemiology of diabetes within the context of sub-Sahara Africa and Cameroon. It establishes the current prevalence rates of diabetes and its epidemiology. Examples of some family-based interventions for the management of diabetes have been drawn from studies conducted on Afro-Americans in the United States of America.

According to the World Health Organisation (WHO 1999), the term diabetes mellitus describes a metabolic disorder of multiple aetiology characterised by chronic hyperglycaemia with disturbances of carbohydrates, fat, protein metabolism resulting from defects in insulin secretion, insulin action or both. The effects of diabetes mellitus include long-term damage, dysfunction and failure of various organs. Diabetes mellitus may present with characteristic symptoms such as thirst, polyuria, blurring of vision and weight loss. In its most severe forms, ketoacidocis or a non-

ketotic hyperosmolar state may develop and lead to stupor, coma and, in absence of effective treatment, death. Often, symptoms are not severe, and may be absent, and consequently hyperglycaemia sufficient to cause pathological and functional changes may be present for a long time before diagnosis is made. The long-term effect of diabetes mellitus include progressive development of the specific complications of retinopathy with potential blindness, nephropathy that may lead to renal failure, and/or neuropathy with risk of foot ulcers, amputation, Charcot joints, and features of autonomic dysfunction including sexual dysfunction. People with diabetes are at increased risk of cardiovascular, peripheral vascular and cerebrovascular diseases. Several pathogenic processes are involved in the development of diabetes. These include processes which destroy the beta cells of the pancreas with consequent insulin deficiency, and others that result in resistance to insulin action. The abnormalities of carbohydrate, fat and protein metabolism are due to deficient action of insulin on target tissues resulting in insensitivity or lack of insulin.

The classification of diabetes is based on aetiological types (WHO 1999). Type I diabetes mellitus is the type that encompasses the majority of cases which are primarily due to pancreatic islet beta-cell destruction and are prone to ketoacidosis. Type I includes those cases that are attributable to an autoimmune process, as well as those with beta-cell destruction and who are prone to ketoacidosis for which neither an aetiology nor a pathogenesis is known. It does not include those forms of beta-cell destruction or failure to which specific causes can be assigned (cystic fibrosis, mitochondrial defects, etc). Some subjects with this type can be identified at earlier clinical stages than "diabetes mellitus". Type II diabetes includes the common major form of diabetes which results from defect(s) in insulin secretion or insulin action,

almost always with a major contribution from insulin resistance. It has been argued that a lean phenotype of type 2 diabetes mellitus in adults found Caucasians (WHO 1999). Other specific types of diabetes include diabetes caused by a specific and identified underlying defect, such as genetic defects or diseases of the exocrine pancreas. Type 1 usually begins in childhood or early adult life and often occurs very suddenly. The body is unable to make insulin and therefore this must be provided artificially by injection. Type 2 diabetes, most often, occurs in adults and develops much more slowly, frequently over several years (particularly if a person is overweight). Type 2 diabetes occurs when the body is unable to properly use the insulin, either because important cells in the body will not allow insulin in (known as "insulin resistance") or because insufficient insulin is produced, and sometimes a combination of the two. As a result, the glucose stays in the blood at abnormally high levels. This type of diabetes mostly occurs in older people; however it is gradually becoming more common in younger people. Many people may not know they have type 2 diabetes as the symptoms can often go unnoticed. The symptoms are: tiredness and fatigue, thrush or genital itching, aching legs, infections, dry eyes or blurred vision, excessive thirst, excessive urination, especially at night and unexplained weight loss (Mahon and Alberti 1997).

Type 1 diabetes is mainly treated by a balanced diet and by intensive insulin therapy which is adjusted to one's eating and exercise patterns. Treatment of type 2 diabetes begins with changes to a healthier lifestyle, exercise and diet. If this does not bring down the level of glucose in the blood then oral medication or insulin injections are started. After 6 years with type 2 diabetes, more than 50% of people require insulin by injection to keep their blood glucose levels well controlled (WHO 1999).

The main indicators of diabetes are: pre-diabetes, any previous abnormalities of blood glucose, overweight, age, sex, history of alcohol and tobacco consumption, family history of diabetes, high blood pressure and ethnicity. Prediabetes, otherwise known as impaired glucose tolerance or impaired fasting glucose (depending on the test used to diagnose), it is a condition in which a person's blood glucose level is above normal but below a level that indicates diabetes. It has no symptoms and can only be diagnosed with a blood glucose test. People who are overweight and 45 years of age or older are at risk for prediabetes. People 45 and older with normal weight may be at risk if they have other risk factors for diabetes, such as family history, high blood pressure, and high cholesterol. Some people with prediabetes go on to develop type 2 diabetes later in life, and recent studies indicate that prediabetes increases the risk of heart disease.

Pre-diabetes is a strong indicator that a person is at risk of getting diabetes. It is estimated that over 30% of people with pre-diabetes will progress to type 2 diabetes. If you have had a previous change in your blood glucose, such as gestational diabetes (diabetes occurring during pregnancy), you are at greater risk of getting type 2 diabetes (WHO 1999). You are much more at risk of getting pre-diabetes and going on to develop type 2 diabetes if you are overweight. Currently nearly two thirds of men and over half of women are overweight or obese. Given that over 90% of type 2 diabetes is as a result of weight gain, many people are at risk of getting diabetes. Even so, the rising epidemic of diabetes could be stemmed through changes to a currently unhealthy lifestyle (WHO 2005).

It is estimated that at least half of all cases of type 2 diabetes could be eliminated if weight gain in adults was prevented. Another perhaps even more important measure for helping to reduce the risk of getting type 2 diabetes includes increasing the amount of daily physical activity, reducing salt intake and stopping smoking (Unwin et al 2001, WHO 2005).

The International Diabetes Federation and World Health Organization predict that over the next 25 years the number of people with diabetes will double and that most of this increase will be in low and middle income countries, such as those of Africa (IDF 1997, WHO 2005). Thus the increase in diabetes is predicted to approach 200% in developing countries and 45% in developed countries. These predictions are based on a combination of a growing adult population, with thus more people at risk of developing diabetes, and increasing numbers of people living in urban centres and thus exposed to risk factors for type 2 diabetes (Mohan and Alberti 1997, Gill et al 1997, Alberti 2001, Unwin 2001), particularly obesity and physical inactivity. However, the predictions do not explicitly take into account current trends in obesity and are therefore best considered to be conservative estimates.

Africa was estimated to have 850 000 people with type 1 diabetes and seven million people with type 2 diabetes in 1995 (Trishna 1996, Gill et al 1997, Unwin 2001, WHO 2005), with the prediction that these numbers will double by 2010. The overall prevalence of diabetes in traditional rural African communities is less than 1%, but is as high as 20% in adults age 20 years and over in some African cities. (WHO 1999, El-Shazly et al 2000, WHO 2005). The risk of type 2 diabetes increases with age, and as in other developing regions of the world, the adult and elderly population of Africa

is increasing rapidly. For example, the number of Africans aged 60 years and over will grow from 22.9 million in 1980 to 101.9 million in 2025.

Thus, type 2 diabetes is already a major public health problem in the African region and its impact is bound to continue if nothing is done to curb the rising prevalence of it risk factors, particularly obesity and physical inactivity. These risk factors have been proven as risk factors for the emerging epidemic of diabetes (Mbanya et al 1997, Gill et al 1997, Unwin et al 2001, Sobngwi et al 2002, WHO 2005).

According to studies conducted in Cameroon, within the past decade, the prevalence of diabetes has known a steady increase. In 1994 the prevalence was 1.8% and 0.9% in adults aged over 15 years in urban and rural areas respectively (Mbanya et al 1995, Mbanya 1997). The rate of impaired glucose tolerance was 5.8% indicating a possible high prevalence of diabetes in the years to come. By 1998 the prevalence was 4% and 1.8% in urban and rural areas respectively (Mbanya et al 1999). Studies conducted in 2000 and 2003 in urban areas revealed an urban prevalence of 5.6% in adults aged 15 years and over (Assah et al 2004, CAMBoD 2004, Shu et al 2004). The studies to date have demonstrated the changing prevalence of diabetes and its risk factors, illustrating how Cameroon is already negotiating the epidemiological transition (Mbanya et al 1995, 1996, Mbanya et al 1998, Sobngwi et al 2002, Mbanya et al 2003, Mbanya 2004). From previous studies in Cameroon, the percentage of undiagnosed diabetes varies from less than 67% to 80% (Mbanya et al 1995, Mbanya et al 1998, CAMBOD 2004).

Results of hospital audits conducted in Cameroon show that complications of diabetes tend to be amongst the first ten causes of morbidity and mortality (MOH 1998, MOH 2003) in some provinces. All these have implications in terms of the cost of managing diabetes, as well as, the complications and potential long-term disability it may cause financially and socially. The development of services must therefore take the family into consideration, especially through the education of patients and their relatives by physicians, nurses and mass media. Unfortunately, guidance on the management of diabetes often falls short of considering the family as vital partners in type 2 diabetes management (e.g. the St Vincent declaration (IDF 1997)).

The management of diabetes requires multifaceted approaches of which diabetes education is one. However, knowledge alone does not necessarily result in improved metabolic control. The real value of diabetes education may lie in offering counseling and support (St Vincent Joint Task Force for Diabetes 1995). Trishna (1996) illustrates that the family and other carers have an important influence on a person's ability to cope with diabetes self-care tasks and they should be included in education sessions and management discussions when possible. The International Diabetes Federation (IDF) recommends that diabetes education, an aspect of diabetes management, should be patient-centred (IDF, 1998). This concept does not necessarily involve the family, whereas patients receive a lot of assistance and support from the family. The management of diabetes in Cameroon is void of standard protocols let alone indicating the role of the family.

Effective diabetes management needs a multi-partnership approach between patients on the one hand and health staff and the family on the other hand. Chicoye (1998)

showed that for a country to improve the quality of life, health outcomes and to reduce the costs of medical care for its members with diabetes, a Diabetes Care Management program has to be developed. However, the family's role is entirely left out by the author whereas the patient spends most of his time with the family.

In the African setting, evidence-based studies on diabetes, especially the social dimension are fewer when compared to other regions of the world. This leaves one with the impression that the continent is still trying to establish its epidemiological basis and explains why the public health concern for diabetes in many countries is low key. This prompts me to turn to studies conducted in United States of America to be abreast with evidence based medical practice relating to diabetes, just to illustrate the importance of incorporating the psychosocial dimension of treating diabetes. Most of these studies on diabetes, linked to the family-based interactions, have adolescents as their main focus and are mainly about Type 1 diabetes. The adults are most of the time studied as individuals within clinic settings. Wysocki et al (2001) in an intervention, set the goals of a study which went beyond those of conventional treatment outcome studies in clinical psychology, by seeking to show that change in a clinically relevant process (parent-adolescent relationship) yielded durable changes in disease-related functioning and health status. He revealed that Behavioural-Family Systems Therapy (BFST) yielded short-term improvements in self-report and direct observation measures of parent-adolescent communication and family relationships. Wysocki's study (2001) suggests that more research on BFST can yield a practicable intervention that can improve adaptation to diabetes among adolescents and their families.

Trief et al (1998) established a relationship between family environment, glycemic control, and the psychosocial adaptation of adults with diabetes care, demonstrating that for insulin-treated adults with diabetes, family system variables do not relate to glycemic control, but they do relate to psychosocial adaptation. This study suggests that future work should explore the impact of family-centered interventions on adaptation. Glasgow et al (2001) point out that although health care providers can make helpful (and sometimes less helpful) recommendations, advice and counseling, it is the patient who must decide which strategies to put into practice and experience the consequences of self-care actions. There is abundant evidence that patients can and do change regimen recommendations after leaving the medical office. Hence, the shift in view about managing diabetes should be from the provider to the patient being the most active decision-maker and problem-solver. It is central to productive patient-provider interactions for management of diabetes and other chronic illnesses (Glasgow et al 1999, Glasgow 2001).

4.3 Medical sociology and anthropology in West and Central Africa

This section makes a review of some of the ethnography relevant to health and medicine that has been done in the Sub-Sahara African region, laying emphasis on West and Central Africa. This review has been done with the purpose of establishing the wealth of literature on medical sociology and anthropology and the gaps still to be filled by subsequent ethnographic research. The section seeks to establish what the place of ethnography on chronic diseases like diabetes in Central and West Africa and whether there is a fair coverage of urban and rural areas. It illustrates that ethnography

here has largely remained a discipline of the village. It is worth noting that most of these works have been done in former British colonies of Africa. Before considering the anthropological literature in detail, I shall review the contribution of survey work in sociology.

Most of the sociology writings in West and Central Africa have focused on traditional politics. For example, authors like Ukpabi (1970), Shallof (1974), Oppong (1975), Wiseman (1979) and many others illustrate the social and political changes that took place in sub-Sahara Africa after colonisation. Traditional medicine is also an area that has received the attention of many researchers. Prominent amongst these are Handloff (1982), Feierman (1985), Bledsoe and Goubaud (1985). These authors described traditional medical practice as an art of healing illness. Still, working on traditional medicine, Kirby (1993, 1997), Fulham and Smith (1988), Fulham and Vincent (2000) and Moukouta (2002) have gone on to explain why people sought care from traditional healers. Also within the practice of traditional medicine Offiong (1983), Van Dongen (1998), Barry (2002) and Aikin (2005) have illustrated that religion (Christianity and Traditional African Religion) plays a vital role in healing illness and this has been highlighted in their publications about witchcraft, psychiatry and diabetes.

Perhaps a larger number of these studies have focused on the practices of 'traditional healers' and 'traditional medicine', to use a convenient pair of terms (though both have the disadvantage of implying a set of unchanging practices). A study conducted by Ahmed et al (1999) in Sudan illustrated that traditional medical practice is widespread in Sudan and traditional healers are well respected by the community. The

main reasons given by people attending traditional healers' services are to obtain treatment and to be spiritually blessed. Van der Geest (1997, 1998) explains that most traditional medical theories have a social and religious character and emphasises prevention and holistic features. But Van der Geest fails to emphasise the fact that traditional medical practices are usually characterised by the healer's personal involvement through secrecy and a reward system. Examples of cross-cultural therapeutic relations have been mentioned frequently in publications from West and East Africa but have rarely been the object of in-depth description and interpretation. Some authors (Lantum 1979, Pool 1994, Rekdal 1999, Olivier de Sardan 1998) hold that colonialist ideology and structural-functionalist anthropology have been biased because they have drawn attention away from what is a prominent feature of African traditional medicine: the search for healing in the cultural context. Lantum (1979) and Rekdal (1999) have recommended that a focus on the dynamics and ideology of cross-cultural healing may be crucial for an understanding of processes generated by the encounters between biomedicine and African traditional medical systems.

Culture and health are interrelated and the former exerts a lot of influence on the latter (Helman 2001), therefore affecting the quests for health care. For example, according to Kirby (1993, 1999), health care facilities in Ghana are not only too few, ill-equipped and under-supplied, but they are also under-utilised. Health care personnel have often noted the irony in the fact that the sick do not make use of the health care facilities when they most need them. Rural peoples often wait until the illness has become so serious that even with emergency measures, there is little hope of survival. Kirby emphasises that the reasons are not simply the lack of community education, the lack of warmth and friendliness on the part of poorly paid health workers, but also

the way that patients perceive the efficiency of health facilities. Also, the long distances that patients travel to access health facilities and the constant shortages of medication equally limit attendance. More constraining than all of these are the conflicting cultures of illness management. In a time of otherwise rapid social and cultural change, peoples of Ghana have not often responded to western medical systems in ways judged appropriate to such systems and have strongly resisted education or coercion to adapt to them (Kirby 1997). But the question that Kirby fails to answer is if this obtains with patients of chronic illnesses like diabetes. He also does not establish the interrelationship between the different medical systems. Though Aikin (2005) makes attempts to answer this question with diabetes in Ghana, he approaches the problem from a psychological perspective, concluding that patients are non-compliant to diabetes care, without seeking to find out the underlying reasons behind that.

However, the few studies on diabetes using sociological survey approaches have been done in Nigeria by Famuyima (1993) Okesina et al (1999) and Ononu (1997), Ghana Ofei et al (1997) and Aikin (2005), Sudan (Ahmed et al 1999) in Cameroon and Tanzania (Mohan and Alberti), Tshabalala (1995) and Tshabalala and Gill (1997) in South Africa. Most of these studies explore the barriers to diabetes care. But they are judgmental as they qualify the Western Medical System of care to be superior to the African traditional medical system. They illustrate that the African traditional medical system has no place in the treatment of diabetes. The studies are limited in that they do not go close to the social actors: patients, the home care-givers and the health staff to get their interpretation of diabetes and treatment. In addition, health staff conducted the studies to establish the knowledge, attitudes, beliefs and perceptions (KABP) in

order to orientate care. Though they are helpful in establishing a baseline analysis for inherent issues in diabetes care, they are also good pointers to the additional necessity for ethnographic research.

A good example of medical sociology about Cameroon is that of Gery Ryan (1998). Ryan studied the behavioural patterns of people towards illness when they are sick. Using a 5-month structured survey to gather data, he designed treatment-seeking approaches for communicable diseases. He and his team of assistants occasionally stopped over the homes of patients to interview them, meaning that he was not immersed in the data collection. Hence he may not have used the Kom language to discern meanings and understand local categories and taxonomies of illnesses. He acknowledged that it was going to be cumbersome to study chronic ones like diabetes. In his publication, Ryan establishes a model to explain the behaviour of people when they are affected by an illness.

There are only a handful of medical anthropology works on infectious diseases globally, but, few on Africa. Of these, only that of Robert Pool who studied illness in Tabenkeng in the Wimbum Kingdom is Cameroon is close to my study. Robert Pool originally set out to study kwashiokor; especially focusing on the cultural factors related to infant nutrition and illness. His original aim was to discover people's ideas or beliefs about food, nutrition and illness and therapy choices. The aim was to lead to recommendations for improving infant nutrition and health and providing acceptable health education. But he decided to explore people's ideas about illness and food and place them in a wider cultural context. He explores both traditional and western medical systems and brings on board the issue of witchcraft. Robert Pool presents the

interpretations of illness as they were discussed in Tabenken. Pool steps beyond discourses about the immediate determinants of disease and appropriate treatment behaviour, and explores the realm of people's interpretation of the ultimate causes of illnesses and general misfortune.

Pool mentions diabetes, the only chronic illness, in his work in just a paragraph but explores the breadth of other illnesses starting from kwioshiokor, and extending to many others. He concludes that the degree of elaboration of explanations vary depending on a number of factors such as education, knowledge of traditional medicine and knowledge of biomedicine. Most informants in his ethnography initially said they did not know what caused illness, that it 'just happened', or it 'came from God', or it 'did not have a cause'. In subsequent conversations, they branched out into elaborating accounts about the world of witchcraft and the supernatural (ancestors) as being part of the explanation. Pool underlines that it may be a culture bound preoccupation for people to explain the most minor ailments, while at the same time shrugging off major disasters and unexpected fatal illness as coincidence. He suggests that people who give elaborate explanations of relatively minor ailments are usually relatively well educated and westernised, and their explanations are strongly coloured by biomedical imagery. By this, Pool wants to illustrate that educated people will explain illness differently from the less educated or uneducated ones. He describes the explanations as entirely in a quasi-biomedical idiom, which Pool argues still has an idiosyncratic character in a rural area such as he studied.

His ethnography reveals that witchcraft takes central stage in the explanation of those illnesses which people think they cannot cure. Also, although people do not attribute

minor ailments to witchcraft, it seems to play a role in the explanation of serious misfortunes, including serious illness resulting in death. Quoting Evans-Pritchard (1937), he explains the role of witchcraft in illness accusation, seeking to draw on Evan-Pritchard's distinction between witchcraft and sorcery. People only revert to explanations in terms of witchcraft when events take an unexpected turn. Illness does occur like any other thing because is should subside if it is treated. If, in spite of extended treatment, it is not cured then it can only be because of witchcraft, the ultimate cause that explains unexpected chains of events (Evans-Pritchard 1937). He concludes that people's conversations about illness seem to support the argument that the role of supernatural causation in Africa had been overestimated.

However, Pool (1994) holds that there was no systematic discussion of the role of witchcraft in the genesis of illness in general and the *ngang* and *bfaa* [illness resembling kwashiorkor] that he was studying. He adds that people thought of witchcraft to have to do with kinship connection. Boyer (1986), Rowlands and Warnier (1988) and Geshière (1997, 1998), while analysing witchcraft in Southern and Eastern Cameroon and Gabon had earlier discussed this idea. Pool concludes his work on the Wimbum by observing that the notion of a 'medical system' is in many ways wider and more inclusive than some authors suggest. Indeed, his argument is that there is no 'system' as such, at all. He also goes further to suggest that no clear line can be drawn between the meaning of indigenous and biomedical (and Christian) terms, and interpretations depend largely on context. Thus, according to Pool the Wimbum do not have a 'medical system', but are confronted with a wide-ranging complex of illnesses and other misfortunes for which all the different kinds of healers, traditional and biomedical should, between them, have a cure. He argues that

medicine is seen not much as a 'medical system' but as part of necessary 'cultural camouflage', like clothing and food that enables one to survive. I shall through this ethnography question Pool's view that a 'medical system, is absent. Pool may have lacked words to ascertain the Wimbum medical system, which my thesis sets out to establish in Bafut and Yaounde and which can help to clarify that of the Wimbum. I think that their medical system is a blend of the traditional medical practice and biomedicine in continual flux.

Going through these publications, I discovered that none has been done on chronic diseases like diabetes, let alone comparing urban and rural areas as I have done with Yaounde and Bafut. My comparative research and its subject matter are in that sense original.

4.4 Ethnography of Cameroon

In this section I have discussed the state of ethnographic research studies in Cameroon (4.4.1), then ethnography in urban areas with main emphasis on Yaounde, where the Biyem-Assi Health District is situated (4.4.2). The Grassfields and Bafut ethnography (4.4.3) concludes this section. While in the Grassfield, the review has gradually narrowed to the Bamenda Grassfield and Bafut kingdom (corresponding to the Bafut Health District). In each of these areas, the review has stretched across several decades, examining the evolution of ethnographic research: from the perspectives of the colonial (period before 1960), early post colonial (1961 to 1985) to the most recent postcolonial period (1986-2003).

4.4.1 Historical Overview

Cameroon has benefited from a handful of ethnographic research from the colonial to the post-colonial era. Some of the ethnography conducted during the early colonial period was by missionaries and colonial administrators. They usually ended with biased conclusions; invariably classifying people's ways of life as 'primitive'. Several efforts were made to stop local practices considered primitive during the colonial period. But at independence, these practices re-emerged as products of cultural revival and cultural identity (Rowlands and Warnier 1988). However the ethnographic works of Phyllis Kaberry (Kaberry 1952) and Sally Chilver (Chilver 1961) took a different turn as they sort to interpret things differently, with the main focus of fostering the wellbeing of Cameroonians.

Generally, there is an imbalance in ethnographic research between the different regions of Cameroon. The few missionary accounts which stretch as far back as 1858 with the establishment of the first Christian Church in Victoria, by the British Missionary Society, helped the German administrators to strengthen their hold on the kingdoms and ethnic groups that resisted their rule (Kaberry 1952, Chilver and Kaberry 1961, Ardener 1968). However, the Germans did some work from 1884 to 1916 during their period of colonisation in Cameroon (Kaberry and Chilver 1961, Ngoh 1987). Their works were mainly topographical surveys, limited to exploring and carving out boundaries between themselves and the British and French and between the different ethnic groups that they identified. Zintgraft concentrated in the western part of Cameroon while Henry Barth explored the northern part.

The period of German explorations considered the Grassfield as an entity, with emphasis on larger units like Bamum (which became a French territory from 1919), Bali, Bafut, Bum, Nso, Kom, Mankon and Widikum. These territories corresponded to those with which they fought wars to establish German hegemony (Chilver and Kaberry 1961, Ardener 1967, Ngoh 1987). When the Germans were defeated in Cameroon in 1916, the territory was shared between the British and the French, and after World War I confirmed in 1919 as Mandated Territories of the League of Nations and later Trusteeship Territories of the United Nations Organisation in 1946 (Nkwi and Warnier 1982, Ngoh 1987). The British sought to study the cultures of the people partly to establish their preferred style of administration of indirect rule [using the local structures] (Hawkesworth 1926, Hook 1934, Ngoh 1987). In this way, the roots of colonial ethnography were planted. The French for their part adopted their policy of 'assimilation' in French Cameroons by applying direct role. Direct rule was experienced by French Cameroonians as forcefully, completely annihilating and erasing the original cultures, replacing them with that of the French. They deposed, imposed and replaced rulers who proved recalcitrant (Mveng 1963). These two administrative approaches led to quite different types of writing on Cameroon: ethnography in British Cameroons and much more self-consciously literary writings in French Cameroons. The British administrators submitted annual reports (Kaberry 1952, Neba 1996, Yenshu and Ngwa 2001) on the Southern Cameroons under the British Colonial State of Nigeria and then the autonomous Southern Cameroons Province [territories that they administered] to the Colonial office in London. Their style of ethnography and writing described the events that had and were taking place in this territory as they perceived and judged. This was to help them in decision-making and in conflict resolution.

While this intensive work was going on in the Bamenda Grassfield, little research of this nature was going on in the French territory. The French had started facing popular resistance from French Cameroons because of their assimilation policies as early as the mid-1920s. The resistance intensified into a terrorist movement and continued in this part of Cameroon until 1971 when the last leaders of the resistance were executed. Neither the colonialist nor the immediate postcolonial ethnographers had time to conduct ethnographic research in this part of Cameroon. The British for their part, faced an easier task to administer their own part of Cameroon because indirect rule imposed less on the day-to-day lives of the people they governed. They set up local governments that were responsible for the day-to-day running of the colony and the administrators reported to them. Even political activities were democratic and leaders were freely chosen into the Houses of Representatives.

At independence, local writers emerged within the former British Cameroons and ethnographic research was done and published, while their counterparts in the French Cameroons settled to write on politics, literature and the economy as had been done by the French colonial administrators. For example, in the early part of the postcolonial era works were published like those of Philip (1970), who wrote on the *Accommodation in a Plural Chiefdom in Cameroon.* The work concentrated on polities of the colonial and postcolonial administrations. Some ethnographic research conducted in Cameroon today still follows this pattern. Another region in Cameroon that has benefited from less research is the ethnic groups of the Lake Chad Basin of Cameroon. But the history of ethnographic research there is more recent than in the Grassfield. Another group of people whose ways of life have been documented are the Pygmies of the equatorial forest of Cameroon but most of these were missionary

accounts (Mveng 1963) of the colonial era. Michael Rowlands and Jean-Pièrre Warnier (Rowlands and Warnier 1988) and Peter Geshière (Geshière 1997, 1998) have made in depth analysis of witchcraft amongst the equatorial forest tribes of the Centre and East Provinces of Cameroon. This explains some of the main reasons why little ethnography is found in what used to be French Cameroons (now Francophone Cameroon). One other factor encouraging the steady strain of European and American researchers to the Grassfield has to be the relatively comfortable climate, considering that this is an area so close to the Equator but cool for most of the year.

4.4.2 Yaounde

This section looks at Yaounde as an urban area. Most ethnographic research has so far concentrated on studying ethnic groups in rural areas, with very little done in the cities. The social research available is mainly on politics, the economy and medical sociology. The city of Yaounde has received very little attention by social scientists. The work of Obama (2001) examines ethnic settlements and the use of language in Yaounde. There may be no ethnographic study of the way of life of people in Yaounde but there are a few social studies describing the life of some of the different ethnic groups that have inhabited the town.

Good examples of sociological studies conducted in Yaounde are those of Paulette Beat (Beat 1988) on prostitution in Yaounde town. Beat portrays prostitution as an activity that women undertake to emancipate themselves. Nga Ndongo (1987) for his part discusses the contents of newspaper publications about life in the city of Yaounde. An unpublished account by Fuller et al (2001 unpublished) can be found about the development of the *Bikutsi* dance, common amongst the Beti people, some

of whom are Ewondos, natives of Yaounde. This work traces the development of the dance from the use of local musical instruments to western instruments in orchestras. Another publication is that of Messina (1999) who wrote about the significance of the word *Ntobo* [stranger]. His work examines the Ewondo view of non-natives. He was motivated by the onset of multiparty politics and the problem of ethnicity that characterised most towns in Cameroon in the 1990s. He analysis issues of ethnic conflicts in the city of Yaounde and explains how the Ewondo people fought to reclaim their culture in a town, which is theirs, but has been lost to *Ntobo* [strangers]. Other works cover the Ewondos as part of the Beti ethnic group of the Centre and South provinces of Cameroon.

4.4.3 The Grassfield and Bafut

The first part of this section discusses ethnography in the Bamenda Grassfield while the second part reviews publications on the Bafut Kingdom. It follows a similar chronology as described in section 4.4 for Cameroon. The main area in Cameroon that has received wide ethnographic coverage has been the Grassfields, especially the Bamenda Grassfield. Most intelligence reports written in this area by colonial administrators like Cadman 1922, Hawkesworth (1926) and Hook (1934) formed the basis for the subsequent ethnography of this time.

In mid-1940 the British Colonial Office dispatched Phyllis Kaberry, a British Anthropologist, to British Cameroons to study the Bamenda Grassfield[1]. The objective was to obtain suggestions on ways that could be used to improve the

[1] The Bamenda Grassfield is the present North West Province of Cameroon. The region constitutes a distinct culture area composed of a number of chiefdoms of varying size and complexity. The chiefdoms range from the small village chiefdoms like those of the Widikum to expansive conquests states like the Bafut, Bali, Kom and Nso. These Kingdoms are linguistically and ethnically diverse but share a number of common features including centralised chieftaincy, the importance of distinctive male and female secret societies each of which exert power by its own right and lay emphasis on hierarchy expressed through titles.

wellbeing of people in the Grassfield, described by British Colonial Administrators as poor. Kaberry explored most of the Grassfield ethnic groups spending as little as two weeks in most and up to 2 years in Nso. Her work led to the publication of many other works on the Grassfield. This led to the first comprehensive ethnographic account published on the Bamenda Grassfield as *Women of the Grassfield* (Kaberry 1952). While she did ethnography, a younger colleague Elizabeth Sally Chilver, (a historian turned into an anthropologist), later joined her in 1958 to study colonial administration before it disappeared and they collaboratively wrote 12 articles in history and ethnography of the Bamenda Grassfield from 1960 to 1974.

Kaberry and Chilver's collaboration led to the research, writing and local publication of *Tradional Bamenda* (Chilver and Kaberry 1968), which became another classic on the Bamenda Grassfield. As Miriam Goheen puts it, in a preface to the new edition of *Women of the Grassfield*, 'This book was the result of their concern that an adequate basis for social and historical studies of the region was needed, one that would be available locally' (Kaberry 2004). By the dawn of independence of British Southern Cameroons in 1961, she had published 11 articles and chapters in books. *Women of the Grassfield* is a comprehensive historical ethnography in a regional setting; describing the structure of Nso politics and kinship including the texture of both men's and women's lives; probing into their households and traditions. Kaberry's book, which set the pace for anthropological research not only in Cameroon and elsewhere, is also an important work for feminist writing and development research, and has been republished in 2004 as one of the seven Routledge Classic Ethnographies in Modern Anthropology. It is one of the earliest studies of the social

construction of gender studies demonstrating on-going negotiations over the meaning of gender roles.

The methodology used by Kaberry built on giving her informants a voice. Her dedication to long-term fieldwork leading to learning the people's local language and using that to extract the local categories and taxonomies, has had a major influence on subsequent ethnographic research in the Grassfield and elsewhere. Her book, because of its uniqueness in the ideas of the time to examine how gender was socially constructed became a significant reference point for the work of Miriam Goheen (1996). Goheen drew inspiration from her and wrote *Men own the Fields, Women own the Crops*, also to examine gender roles and equality, including issues of power in the Nso society. Besides, Kaberry's work inspired Goheen (1996a, 1996b, 1999) to examine how far there is a balance of power amongst men and women in Nso, reassessing issues of equity in Africa.

Kaberry and Chilver jointly published a range of works with *Traditional Government in Bafut, West Cameroon; Traditional Bamenda: The Pre-colonial History and Ethnography of the Bamenda Grassfields and Chronology of the Bamenda Grassfield* in 1963, 1968, 1970), respectively, being very relevant to ethnography. Other publications by Chilver (alone) explored the Bamenda Grassfield in context. Chilver's publications were in history and ethnography of Grassfield Kingdoms.

Kaberry and Chilver raised a host of younger Cameroonian anthropologists from the Grassfield, who later joined them and have carried on with ethnography in the Grassfield during the postcolonial era. Aletum Michael (1973, 1974) researched and

published on the Bafut and Nso, and Paul Nkwi (1979, 1982) focused on Kom and the Grassfields. These two both studied traditional power institutions of Grassfield people. Jean-Pièrre Warnier, a French anthropologist, worked very closely with Paul Nkwi. He has jointly published articles and books with Nkwi on history and people of the Grassfield and has endeavoured to extend his ethnography to other parts of Cameroon, especially the Bamileke Grassfield. Also, in this period is Fanso Verkijika (1990), Chem-Langhee (1980 and 1996), who focused on studying the political institutions of the Nso Kingdom. These anthropologists-historians later grouped themselves and created the Kaberry Research Centre in Bamenda as a way of fostering anthropological research in the Bamenda Grassfield. Foreign and Cameroonian anthropologist subscribed to this centre and generated a lot of anthropological works. Their works were published in the *Paideumia* and *African Crossroads*. Websites have been created to promote publication of research in the Grassfield. The University of Kent[2] has played a great role in doing this, especially with the recent publication of Hermann Gufler's *Affliction and Moral Order in Yambaland* published in 2003. The Reverend Father turned anthropologist studied ritual life as ways of handling misfortune and illness among the Yamba people of the Grassfield. However, forerunners of works on ritual life have been Richard Fardon (1984, 1985, 1988) and Richard Dillon (Dillon 1973) who wrote about rituals in Bali. Meanwhile, Peter Geschiere (1986) and Michael Rowlands (Rowlands and Warnier 1988, 1995) have written on witchcraft, trying to reveal the meaning attached by people to it. Richard Engard's (Engard 1988, 1989) publications have examined the notion of power and myths.

[2] Publications of the Bamenda Grassfield Ethnography can be found on the University of Kent Anthropology department website: http://lucy.ukc.ac.uk/.

In the second postcolonial phase of ethnographic research in the grassfield, anthropologists from the United States and Europe [especially the United Kingdom] and Cameroon have made more insights into Grassfield Ethnography. Some authors (Arderner 1995, Fowler and Zeitlyn 1996, Zeitlyn 1993, 1994) have re-examined the concept of the Grassfield, redefining the people of this region. Meanwhile, Diduk (1993), Asombang (1999), Gufler (2003) expounded on the power of rituals in the Bamenda Grassfield with specific case studies on twins, traditional healers and palaces. The issue of palaces led into the declining power of the Grassfield *Fons* [Kings] discussed in the *African Crossroads* by Simo Mope (1996), Fisuy (1996), Jua (1996) and Goheen (1996). This review is not exhaustive. However, a Grassfield-working group has emerged in the United States of America to foster research in this area of Cameroon.

Turning to Bafut, ethnographic studies on Bafut are relatively plentiful. In some of the works, Bafut is treated as one of the Grassfield Kingdoms. In others, Bafut is looked at as a kingdom with inter-kingdom connections. Hawkesworth (1926) and Hook (1934), as Native Authority administrators, had written colonial annual and intelligence reports on the people as far back as the 1920s during their administration of the Bamenda Province (Niba 1996). These works provided baseline information that later served as guides to subsequent anthropologists like Kaberry, Chilver, Ritzenthaler and many others who stayed in the kingdom for ethnographic studies. Kaberry alone and later with Chilver had studied Bafut as part of their work on the Grassfield kingdoms from the 1940s, and they later published *Traditional Government in Bafut, West Cameroon* (1963). Robert and Pat Ritzenthaler who wrote about the Fon of Bafut and his sphere of influence. Their works were published as

Cameroons village: an ethnography of Bafut (1962) and *The Fon of Bafut (1966)*. In these two publications, there was only one informant – the *Fon*. Aletum, himself a Bafut native, has published two works (Aletum 1973) on the tradition of the Bafut Kingdom. Richard Engard published two works: *Myths and Political Economy in Bafut, Cameroon* (Engard 1988) and *Dance and Power in Bafut, Cameroon* (Engard 1989). The works explain how economic and political power is revealed through ritual performance. Furthermore, Michael Rowlands (1989) has also published on the Bafut tradition. The most recent works published on Bafut are those of Raymond Asombang (1999) on *Sacred Centers and Urbanization in West Central Africa* and Eno Belinga (Belinga 2001) on the *Fon of Bafut and the Palace*. Asombang's work focuses on the centrality of power within the Kingdom of Bafut, while Belinga describes the palace and power structure within it. Of all these ethnographers, Michael Rowlands still works in Bafut. He has published on the Grassfield palaces as part of his efforts to encourage the development of Museums and the preservation of Palaces in Africa; and Bafut is one of those he has been emphasising.

4.5 Concluding note on literature review

Ethnography in the colonial and first postcolonial periods focused on studying the history, economy, structures of palaces, and issues of power relations and negotiations in the African Kingdoms, as illustrated with the wealth of literature on the Bamenda Grassfield of Cameroon. Issues of witchcraft, ritual, religion and the conflicts inherent in them were examined. The first post-colonial period continued in the same manner. But more recent work has branched out; and while some of it has involved a

deconstruction of concepts that were examined in the colonial and early post-colonial periods, there has also been a deepening of work on familiar topics of power, change, ritual and gender. However, a major innovation in the recent second postcolonial period has been to include concepts like illness into the subject matter of ethnography. My work will examine diabetes, a chronic illness, a topic which never figured in previous ethnographic studies. It is hoped that this study and others that will grow out of it, may in their turn be considered as baseline ethnography about an important public health problem and be used as guides for subsequent policies and programmes on diabetes, yet to find their places in sub-Sahara Africa.

Chapter V

The case study of *Taa* Samuel

> ...My sick started when I was an inspector of education at Wum in 1984. As an inspector I used to receive a lot of gifts from people in drinks and food. I used to drink a lot of beer, and then later I was told in 1982 that it was not too good so I had to leave it. When people realised this, they were giving me lots of sweet drinks like *Malta Guinness*[1]. I could sit at once and drink six, seven of them. One day I was not feeling fine at all. I was very sick and drinking a lot of water. I went over to the General Hospital to consult and I was sent to the Laboratory. When the results were presented, the doctor told me that I had diabetes. I did not quite understand what that meant. He told me that there was a lot of sugar in my blood and stopped me from eating and drinking sweet things. I stopped and was only drinking wine. All along I have been living like that until those people of the NCD[2] programme came here and instead started telling us that you can eat everything but in moderation. That is how I have been living till today...
>
> (*Taa* Samuel[3], diabetes patient in Bafut – 12 July 2002).

5.1 *Taa* Samuel, his status in Bafut, my connection to him

This quote introduces the case study of *Taa* Samuel, a diabetes patient in Bafut. *Taa* Samuel was a 75-year old man. He was a father of seven children and head of his extended family. He was a very important personality and held several positions in Bafut. Amongst these positions were: Chairman of the *Manjong*[4], pioneer president of the Bafut Diabetes Association, former chairman of the Presbyterian Church Agyati and Chairman of the Building Committee of the Presbyterian Church Agyati. Bafut people knew him as a good initiator and organiser of programmes. *Taa* Samuel was one of the patients that I visited and interacted with regularly. My first contact with

[1] *Malta Guinness* is a non-alcoholic Guinness Cameroon Company Limited product.
[2] NCD Programme. This was a project known as the Essential Non-communicable diseases Health Intervention Project that studied Asthma, Diabetes, Epilepsy and Hypertension. It was the project that marked the advent of NCD care at primary care level. Bafut and Biyem-Assi were the two sites.
[3] *Taa* is a prefix that precedes a male adult's name. At the same time Taa in Bafut is father in English.
[4] Bafut *Manjong* is a local development and cultural association which designs and monitors cultural activities in for the Bafut people. *Taa* Samuel was the pioneer president of this association.

him started when he invited me to his home. Initially, a nurse accompanied me but subsequently, I continued my interactions alone. In the course of this, I discovered three months later that he was the father of one of my patients in Biyem-Assi.

The above quotation is drawn from notes I took while conversing with *Taa* Samuel and his wife during one of my visits to his home. These and other data for the following chapters come from interview transcripts, fieldnotes and conversations that build up this ethnography. The quotation highlights how most patients become aware of their diabetes status only through chance events, when they respond to its signs and symptoms. Also, the quotation illustrates that when patients are diagnosed in the hospital, they, quite often, do not understand what diabetes represents. Like *Taa* Samuel, many patients are prohibited certain food, but as time passes, they mature in adjusting to the disease and try to understand it in their own way, and act to manage it as they think rationally appropriate. Another important issue from the quote is the changes in information provided to *Taa* Samuel after he was diagnosed with diabetes. The doctor prohibited him from eating sweet food and drinking sweet beverages, hence the issue of relating diabetes to sugar. But the doctor's prescription was interpreted as contradictory, fifteen years afterwards. To the surprise of *Taa* Samuel, a team of researchers made him understand that he should eat everything in moderation. Rightly or wrongly, this might have been a scientific innovation, which *Taa* Samuel could not easily understand and identify with. In that confusion, his wife gave the support she thought appropriate though at times *Taa* Samuel ate and drank what he thought was good for him, sometimes with the disagreement of his wife. She wanted the clinic prescriptions on diet to be respected, in line with her own understanding of

what diabetes management required. This behaviour illustrates that clinic information is never accepted as dogma but carefully screened and reorganised by the patient's family, using their lay knowledge and beliefs.

Before and after the day on which I recorded the remarks from which I extracted this quote, *Taa* Samuel often complained about his declining health. His clinic records were quite revealing, as he went more frequently to the hospital than ever. In this conversation and others, he named several of his family members living with diabetes. He wondered if diabetes was not a family disease; and later concluded that it was because his father died of diabetes complications. He also observed that one of his brothers and two of his children also have diabetes. He became sad, as though to confirm my feeling that he might not have thought of this before, and started to realise from our conversation when he commented, 'It is like diabetes is a family disease'.

5.2 Setting up of the Diabetes Association

Realising that his family had a history of diabetes, *Taa* Samuel agreed to spearhead the formation of the Bafut Diabetes Association and was elected the pioneer President on 18 October 2002. After the election, plans were made to celebrate World Diabetes Day (WDD) scheduled for 14 November 2002. For that reason, a preparatory meeting was scheduled for 6 November 2002 amidst controversy resulting from the coincidence of the date of the meeting and the celebration of the 20th anniversary of Mr Paul Biya – as President of Cameroon. Some people questioned whether the meeting should be held, given that participants were few to form a quorum. His Vice-

President, who replied, resisted *Taa* Samuel's suggestion that the meeting should be postponed to next year.

> ...No! No! I think that we should hold the meeting. You are saying that it should be postponed; do you know what can happen between now and next year? Next year some people will not be there...
>
> (Vice-President, Bafut Diabetes Association, 6 November 2002)

After this reaction, *Taa* Samuel agreed that the meeting should be held, so the WDD celebration was planned, a draft constitution examined and a song composed. When the song rehearsal was going on Taa Samuel was collecting information from me, and wrote a speech, something he revealed to me only at the end of the meeting.

5.3 His illness and death

Four days before WDD *Taa* Samuel had a stroke and was admitted at the Bafut District Hospital. People streamed in and out of the ward where he was admitted, to greet him. I could hear people saying, '*Whe*! *Pa* was in Church yesterday singing happily. What happened?' Many of the well wishers suggested reasons for the stroke [*Mbenou Ifoule kfô* or *à se fa* (your one side of the body is dead or one side of the body is not working)]. While some attributed this to the fact that *Taa* Samuel was tired because he overworked himself, others said somebody was responsible for the act because he had quarrelled with a man addressing him with 'bad words'. Other people said that he had the *Mbenou Ifoule kfô* [stroke] because the Road Construction Company (Koop/Buns) dug near to the wall of the daughter's clinic under construction and he reacted angrily, thereby facilitating his developing a *Mbenou*

Ifoule kfô. The least mentioned of the causes was relating it to diabetes as one complication.

Taa Samuel spent two days at the district hospital and his daughter, who lives in the United States of America (USA), requested that he should be referred to the General Hospital in Yaounde. The doctors initially hesitated to accept the daughter's request, assuring the family that it was a minor problem that could be treated by the Bafut District Hospital, but family pressure was stronger than they could bear. They prepared referral documents, appointed a nurse and hired an ambulance for *Taa* Samuel's referral on 13 November 2002. Before departure, *Taa* Samuel handed the speech he had prepared for WDD to the Vice-President. He encouraged his Vice-President and other members of the association to work hard for the success of WDD. When he was brought out from the ward, he cried in protest but they drove off for Yaounde. The nurse who accompanied *Taa* Samuel to Yaounde returned the next day by 10 am and narrated the story of his journey to curious people, who were attending the WDD event:

> ...The daughter in the USA kept calling every time. During the six hours journey she called every 20 to 30 minutes to know about the father's situation. Since I had the BP machine with me I was taking *Taa*'s BP and reporting to her. She called and called until we arrived, and I handed him over to the doctors in Yaounde. Before we arrived, the daughter and other family people were waiting...
>
> (Nurse in Bafut District Hospital, 14 November 2002)

As the nurse devoured a dish of food prepared for the WDD celebration, he answered questions related to their journey from Bafut to Yaounde. One onlooker commented cynically,

> ...They have the money, so they can spend. If it were some of us we would have died the same day here. Just imagine how much was spent on the ambulance and then the General Hospital. Some millions...
>
> (Community person in Bafut, 14 November 2002)

People felt sorry for the fate of *Taa* Samuel who had formed an association, and organised a ceremony in which he was not participating.

A week afterwards, I visited *Taa* Samuel at the General Hospital in Yaounde. His doctors assured me that he could be discharged in six days if his leg got better. I returned to Bafut with that message. But on Sunday 24 November at 4pm, when I was conversing with the doctor and telling him how *Taa* Samuel was feeling better, he replied, 'But he died this morning'. The reply of the doctor ended our conversation. I moved to *Nsani*[5] to inform his Vice-President. I met him drinking in one of the bars so I informed him about *Taa* Samuel's death. He was shocked and reminded me,

> ...You see, the careless statement that I made on that day that we were planning the celebration of the WDD? If someone heard, he will think that I am responsible for his death...
>
> (Vice-President, Bafut Diabetes Association, 24 November 2002)

He closed his mouth with his palms and shook his head in regret. He returned to the bar and I joined him in drinking.

The death of *Taa* Samuel started another moment of anxiety, uncertainty and questioning. People started pondering what had killed him. Reasons similar to those that were put forward when he suddenly developed the stroke were suggested. The

[5] *Nsani* is a junction, which serves as an assembly point and centre of a quarter or village in Bafut. A *Nsani* is created whenever a new quarter or village is created. The *Nsani* I am talking about here is *Nsanimunwi*, the nearest to the Palace and a symbol of the junction where Bafut people gathered and assassinated the woman who founded the present site of the Bafut Palace.

next day was when *Takumbeng* had to begin blessing Bafut. It was the advent of the dry season when it is believed that many bad things set in so the Bafut land had to be protected from evils like diseases, witchcraft, death and hunger liable to affect the kingdom. *Taa* Samuel's death was one of the events considered in Bafut tradition as an evil that came with the dry season. He was the second Bafut elite to die within a month. His case was peculiar because he had been very influential in so many activities in the Bafut kingdom.

5.4 The funeral, *Takumbeng* and the *Fon*

The family members and other mourners of *Taa* Samuel transferred to his compound to mourn for a week while waiting for the corpse to be brought from Yaounde. Though it was a mourning ceremony, people transformed it into feasting. Some people remarked, 'There is *Allah*[6] at Agyati. One cannot mourn with an empty stomach'. The first remark meant that there was food (feasting) at Agyati and the second that mourning goes with feeding. On the eve of the corpse arriving, the nurse and I went to see how funeral preparations were being done. We met one of the sons who introduced the nurse to some family members as the person who cared for his father when he was being transported to Yaounde. One complained, 'God has not accepted that *Pa* should come back'. The son, on his part, explained.

[6] *Allah* is an Arab word used by Moslems to call God. In Bafut, *Allah* is not a word in Bafut Language. Rather, people use the word to denote feasting, referring to how feasting is done during the Feast of the Ram. The feasting is done with a lot of generosity, to the extent that all attendants, invited or not, have enough to eat and drink, as a way of pleasing the ancestors.

> ...Papa was already well but they wanted to see what was happening to his leg so they put him on a drug and were supposed to replace it with one that was more effective but they delayed. By the time they came Papa could not more respond, so he gave up [died]. Those doctors in the General Hospital are careless. They are not effective. They don't know their job. How can you control somebody of his diabetes and he dies of a minor problem?...
>
> (Son of *Taa* Samuel, Bafut – 28 November 2002).

Since *Taa* Samuel was the President of the Diabetes Association, the doctor suggested to the Vice-President to prepare an eulogy for the funeral service. He refused for fear that people in Bafut could accuse him of killing *Taa* Samuel, in order to replace him as President. He reminded us of the death of a Mayor, who had died a year earlier and people attributed the cause to his assistant. It seemed that the role of the Diabetes Association was going to be minimised, whereas a number of people wanted to see that highlighted through an eulogy. During a Church service organised in *Taa* Samuel's compound, another member of the diabetes association opted to prepare and present the eulogy of the association.

About 7000 mourners attended the funeral ceremony, organised by the family on 30 November 2002. The different groups attending the ceremony presented fourteen eulogies, full of praises for the achievements of *Taa* Samuel. After the Church funeral service, the family, the Church associations and the members of *Kwifor* took the corpse to the family cemetery for burial. The rest of the population stayed in the houses belonging to the brothers of *Taa* Samuel to eat and drink what had been prepared to entertain mourners. To facilitate entertainment and make sure that everyone was attended to, sitting was organised according to different groups represented in the funeral. Though the Diabetes Association was given priority, the entertainment committee faced difficulties about the food and drinks to offer. Finally, the entertainment committee settled on sweetened soft drinks and a litre of red wine

but no food was offered because a consensus could not be reached on the choice of food. Some family members turned up about five times, made promises but no food was offered. The association initially rejected the sweetened drinks but later decided to exchange them for beer. While these manoeuvres were going on, the other groups were eating. The Diabetes Association stayed on without food and dispersed in anger in the evening.

Most people pondered about the death and were deeply conversing trying to construct the different causes of *Taa* Samuel's death. A few people knew that Taa Samuel was a diabetes patient and was liable to develop a stroke. Many other causes of his death suggested by people were similar to those voiced when he first had the stroke. Some concluded that he was killed through witchcraft because of his undesirable behaviour towards other people. The death of *Taa* Samuel received different interpretations that completely overlooked stroke being a complication of diabetes.

I could see that *Taa* Samuel's family members living with diabetes remained in a state of uncertainty, anxiety and expectation, concluding that their fate was clear. They were in this state not only because their father had died of a complication of diabetes but also because those who were diabetic may soon die suddenly. One of *Taa* Samuel's brothers was diagnosed with diabetes, one month after the funeral. Most people interpreted the cause of the diabetes to be related to the fact that the family of *Taa* Samuel failed to entertain the Diabetes Association during the funeral. In addition, the daughter, who had been regularly receiving treatment at a clinic in Yaounde, ceased attendance and adopted traditional medical therapy because of her lack of trust for biomedical therapies.

Taa Samuel's death revealed several aspects of local Bafut tradition, but equally had aspects which appeared to some to flout tradition. It occurred when *Takumbeng* was starting one-week activities for purification of Bafut in the different villages and quarters scheduled to end on Saturday 30 November 2002, the same day that *Taa* Samuel's burial was planned. The *Fon* authorised the burial and funeral of *Taa* Samuel without restrictions. People were surprised and wondered why the *Fon* gave *Taa* Samuel's family a privilege that others had never received. Some people suggested that the *Fon* acted against traditional norms, thereby exposing Bafut to the wrath of the ancestors. The role and authority of the *Fon* was questioned at least implicitly in this instance.

5.5 Themes

I have presented this extended case as a prelude to the detailed ethnography to be discussed in the next three chapters. Some of the main themes that emerge in this example run through these chapters: questions related to compliance, the relationship between patients and clinic staff, the relationship between the patient and the family, lay understanding of diabetes and its risk factors, relationships between individual events and a traditional ritual calendar, dietary issues, and coping mechanisms. That said, the themes that emerged in this case study are not an exhaustive list of the themes that will be discussed in the next three chapters.

Diabetes in Bafut is equated with signs and symptoms of an illness. But it may not necessarily mean that people link complications of diabetes to diabetes itself. Instead, complications may be singled out as indicating a completely different illness. The majority of people think of diabetes as an illness developed from a high consumption

of sugar. As in *Taa* Samuel's case, most people perceive the cause of stroke in a manner unrelated to diabetes. From this perspective, looking good, healthy and participating in daily activities like *Taa* Samuel always did was taken as tantamount to being well. Both immediate and underlying *social* causes of death are those that seem inherently most convincing to people faced with a person's rapid deterioration and death. A purely clinical aetiology may be acknowledged by some, but it is not as convincing an explanation for the majority. For that reason, as we see in this case study, a death resulting from a complication of diabetes becomes dissociated from diabetes and its cause found in the social realm. Hence medical and traditional knowledge are represented as parallels in the quest for a diabetes treatment. What is particularly interesting in this case is to find that in Bafut circles, seemingly attuned to biomedical knowledge about diabetes, a biomedical explanation was still widely seen as unconvincing and disregarded by many, when faced with the particular instance of this death. *Taa* Samuel after all was the new president of the recently formed Diabetes Association. If any social circle in the area might have been expected to articulate a clinical explanation, surely this was it? In practice, as we have seen matters were not so clearcut.

In Bafut and other tribes of the Grassfield, the cause of a person's death is always attributed to some superstition (witchcraft, ancestors and gods). Though this case study does not directly highlight ancestors and gods as being responsible for the death of *Taa* Samuel, it suggested events that were seen by some people as indicating possible ancestral intervention. The failure to feed the Diabetes Association is one of those events created by *Taa* Samuels's death and used to interpret the occurrence of diabetes in one of his brothers. The illness, death and funeral of *Taa* Samuel depict a

transition to another world giving him the status of an ancestor. As an ancestor, he has acquired the powers to punish defaulters. That is why certain people quickly linked the cause of the brother's diabetes to the failure to feed the Diabetes Association.

The fact that the family of *Taa* Samuel was unable to know exactly what food and drinks were suitable for diabetes patients is illustrative of the uncertainties about people's dietary habits. These uncertainties result from changing medical advice based on scientific innovation, but patients may interpret that differently. These interpretations by patients facilitate their adoption of patterns of treatment considered by clinic staff as non-compliant. The complexities of social life, the underlying cultural norms and values; and expectations from people make decisions difficult to take. The *Fon* also is entangled in the underlying web of cultural values and in responding to the needs of his ancestors and the people over whom he rules. He is expected to satisfy both parties to avoid social calamities, but events may coincide in a way that leads some to question whether he has breached ancestral norms, which he is expected to respect and protect.

5.6 Conclusion

Using this case study as a revealing springboard, I have attempted to articulate from within the interpretative tradition common to all ethnographic work, a number of core issues facing diabetes management in the practical context of people's everyday lives. The development of this ethnography focuses on how people understand and interpret the causes and treatment of diabetes. This understanding and interpretation has

organised the meaning of diabetes, and shaped the patterns of behaviour relating to treatment as a means of accommodating plural medical landscapes. The chapters that follow this case study explore diabetes within the perspective of comparative medical anthropology. The comparison I make is between rural and urban settings in Cameroon, and between modern and traditional interpretations of the chronic illness that diabetes entails. This comparison provides a critical analysis of biomedical categories about diabetes as socially constructed and managed in both urban and rural areas.

Chapter VI

Clinic perspectives on treating diabetes patients

6.1 Introduction

> ...No question is silly. I want to ask a question. 'What is diabetes?' The answer is that diabetes is a metabolic disorder when your body is unable to control sugar in your body, and it raises the level. This happens because of less insulin or resistance. There are two types of diabetes: Insulin Dependent Diabetes Mellitus (IDDM) and Non-Insulin Dependent Diabetes Mellitus (NIDDM). The first is type 1. Those who have to take insulin throughout their life, take so that it can reduce the sugar level. The second is type 2. The insulin is there and your cells don't use it properly. It helps to bring sugar to a normal level. Our body requires the substance we call insulin and our body can digest it. It helps to take blood into our cells and convert the sugar to another substance – glucose – that is stored in the liver. When this is done, then our sugar level is controlled. When it's lacking or not enough, then we develop diabetes. At this time, we develop some signs and symptoms. We drink a lot of water, urinate much, loss much weight and feel tired...
>
> (Nurse, clinic in Biyem-Assi, 21 September 2001).

These comments were made at one of the regular health talks given during a session at a Diabetes Clinic in Biyem-Assi. The comments illustrate one of the more explicit efforts to communicate medical knowledge to a group of diabetes patients that I came across, though this kind of talk was typical of the health education efforts of this particular clinic. This chapter focuses on the work of clinics or hospitals in Biyem-Assi and Bafut where diabetes is treated. I present here, the perspective of clinic staff, especially those in positions of responsibility and authority. I want to show how clinic staff represent their work with diabetic patients, and the obstacles or opportunities they believe that they face. I start in the next section by describing some of the settings in which diabetes is treated, whether in special diabetes clinics or as part of the everyday provision of healthcare (6.2). The clinical environment is described, both as an institution of biomedicine and as a local cultural setting. I discuss the procedures I observed or had described to me. I then go on to examine staff perceptions of relationships with patients in the two following sections (6.3 & 6.4). The first of these looks at the ways in which medical staff talk about patients and patient attitudes to

managing their diabetes, and how clinics present diabetes as a disease to their patients. What comes across most strongly is a sense of frustration on the part of medical staff about patient behaviour. Try as they might, clinics cannot regulate patient behaviour outside the clinic, and the dismay that patients fail to 'comply' with clinic guidelines colours staff attitudes.

The issue of 'compliance' threads through this and the following two chapters and is discussed further in section 6.4. The whole question of compliance is moreover complicated by the fact that staff knowledge of diabetes, and beliefs about appropriate and effective treatment, vary greatly. Diabetes is a 'new' disease for staff as much as for patients. A later chapter (Chapter VIII) will explore in some detail how this predisposes some staff to subvert clinic treatment practice by not only turning a blind eye to traditional healing, but even by actually facilitating bringing in traditional healers to 'medical' settings to 'supplement' or modify treatment. The central paradox that this chapter addresses is why the authority of biomedicine is far from pervasive in the context of diabetes care. If we see the work of the clinic, as in part, a cultural performance to persuade patients to trust and adhere to 'expert' medical knowledge, then my ethnography suggests that this performance is not currently as convincing as senior staff would themselves hope.

The four clinics from which I recruited my patients were the Etoug-Ebe Baptist Health Centre, and the EPC Djoungolo Hospital Annex, both in Biyem-Assi; and the District Hospital and Presbyterian Health Centre, both in Bafut. Except for the District Hospital in Bafut, Christian Health Boards own the rest. Coincidentally, these are health units with high patient flow for diabetes patients. By the time I was beginning

fieldwork, they had been running NCD clinics for three years. These clinics were all funded by a grant from the University of Newcastle upon Tyne Medical School in the United Kingdom, and the project was run and co-ordinated by the HoPiT Research Group of the Faculty of Medicine in Yaounde, Cameroon. In the course of my fieldwork, the number of clinics in these two study sites increased by two each, all set up in public health units. I occasionally visited these new clinics in order to compare with the four settings where my fieldwork was concentrated.

6.2 Treating diabetes: clinical settings and procedures

This section describes the biomedical settings in which diabetes is diagnosed and treated. A great deal has been written about clinical settings in the West; much less has been written about clinical settings in Africa, and even less related to diabetes. There is no space to describe how each of the four clinics operated, and to do so would be repetitive. But I shall outline clinic routines in two of the four, one in Biyem-Assi, the other in Bafut.

At the time I was starting fieldwork in July 2001, the Etoug-Ebe Baptist Health Centre (EBHC) diabetes clinic had 87 patients. By the end there were more than 120 who regularly attended consultations. The diabetes clinic did not occupy a space of its own; instead, the health centre was designated as a diabetes clinic on specific days. Patients with an appointment for a particular day started to arrive at 5 am. Patients arrived, collected their appointment numbers, went to the cashier and paid 500 FCFA [50p] to have their glycaemia levels checked. As a routine, the cashier wrote the amount paid

and patient's number in the handheld medical record, for that day. Patients queued until the laboratory technician tested for blood glucose, then they moved to the smaller hall for weight and blood pressure measurements. One of the regulations in the clinic was that any patient who arrived after 8 am had to pay 750 FCFA as punishment. In due course, the senior nurse, the head of the health centre, also in charge of the diabetes clinic, decided that a patient would not be attended to after 8am. The laboratory was reasonably well equipped but faced problems getting reagent strips for blood glucose measurements. This was later resolved when a supply unit became available in Yaounde. In consultations, patients were prescribed drugs and given advice on the measures they should adopt to modify their diet and more generally their lifestyle. But there was little or no education tailored to particular individual needs on the grounds that too many people came each day. (See quote below).

> ...So you cannot have enough time to counsel a patient considering the number who come. You have to hurry because others are waiting outside...
> (Declaration of a nurse in Biyem-Assi, 15 November 2001).

The clinics regulations were very strict and waiting time, before and after consultations, were lengthy. In this way, the clinics imposed a form of discipline on patients who had no alternative but to conform whilst they were within its confines. I can consider this as a ritual of depersonalization, a process familiar in a number of health studies (Helman 2001, Broom and Woodward 1996, Nichter 1993, Good 1994, Kleinman 1978), with the clinic staff being the main actors, and the patients converted into numbered cases to be processed speedily and en masse. Exchanges between staff and patients in the clinics were mainly instructional and one directional, and very

brief. The only significant exceptions were the few patients whose high social status guaranteed them a much more personal and speedy procedure.

Higher status patients are treated differently. For example, high ranking and rich patients are given preferential treatment, more patience, longer time and more opportunity for discussion. Sometimes, this treatment is to protect patients, who hold important posts in the public administration. These high social status patients received these favours only partly on account of staff deference, and just as much because such patients insisted on more personal advice. They had the confidence to ask questions arising out of their recent experiences and any 'lapses' in observing prescribed regimes of diet or medication, in an attempt to gain explanations attuned to their individual circumstances.

More typically, staff communicated with patients' instructions, blame and accusations. Little explanation was given by staff about why certain symptoms or signs appeared and why there were certain complications. Any explanations, in a general manner, were set aside for the health education talks, exemplified in the extract opening this chapter. Direct staff-patient interactions in one-to-one consultations (figure 9) were to read the test results, verify if the patient required more drugs or an increase in the dose. Even so, these brief individual consultations raised some of the questions which were addressed in the health education talks. Some of these questions asked were:

> 'Can a person with diabetes be a blood donor?'
> 'Can Type 2 diabetes degenerate into Type 1?'
> 'What then is the normal level?'
> 'From 94 to 45. What does that mean?'
> 'What of drinking water? I received a note saying that I should not drink water.'
>
> (Sample questions asked by diabetes patients at a health education session at Biyem-Assi, 21 February 2002)

After treatment, health talks (see figure 10) regularly took place, and patients were advised to remain behind to attend them. Each health talk took a different topic, and had been designed to provide important information to patients over a period of visits.

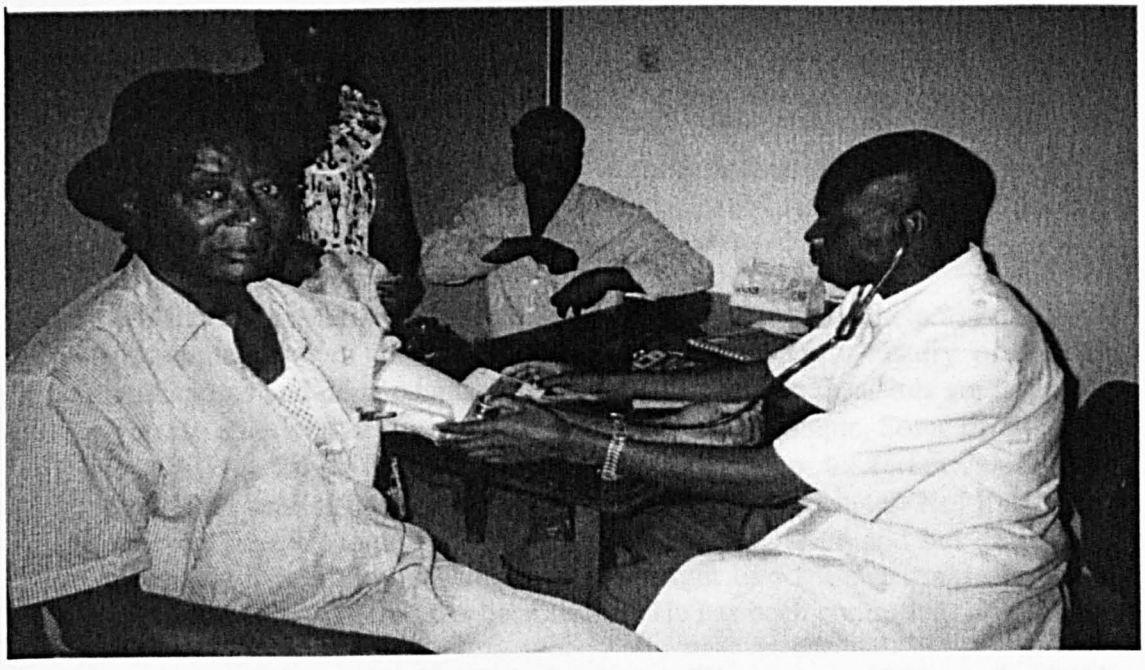


Figure 9: A nurse consulting a diabetes patient at Biyem-Assi

Figure 10: Health talk session at a diabetes clinic in Biyem-Assi, Yaounde.

Topics included: the definition of diabetes, dietary advice, the storage and administration of insulin, foot care and complications of diabetes. Though these topics focused on separate issues, information from one topic overlapped with another. The case quoted below from my fieldnotes offers a particularly illuminating instance of both the tone and content of the advice a nurse might provide to patients during one of these health education sessions. Note particularly here the reference to the need to manage diabetes over the long-term, and the warning against the advice of traditional healers that they can 'cure' patients' diabetes:

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

These health talks were the initiative of two or three individual clinic staff members, who saw them as a vital part of the support that the clinic could provide. There can be no doubt of the sincerity of the effort to communicate what was believed to be useful information. But from an ethnographer's point of view, it is important to note that not many patients shared this enthusiasm. Many chose not to attend these sessions. So after consultations, they left, neglecting to collect their handheld medical records (given that these were handed to them only after the health talks, precisely as an incentive to attend the advice sessions). Some patients only returned in the course of the month, before the next clinic sessions, to collect their records and perhaps purchase some of the drugs prescribed. A good number of the patients, many of whom

had been attending the clinic for over a year, thought that the information given to them was repetitive and monotonous. Or they claimed that the health talks added nothing to what they already knew. Some patients – if they had the financial resources – preferred to consult on a different date, paying more in an effort to choose a time when the nurse might have adequate time to listen and discuss their symptoms and complications with them. Nonetheless, having painted this picture of uninterest in or even avoidance of the health education talks, I need to emphasise that despite a prevailing unenthusiastic mood significant numbers of patients did stay and attend, and they did ask questions. The clinic would hardly have bothered to maintain these sessions if they attracted no audience whatsoever. What I seek to convey is that the conviction of the staff who put on these sessions as to their value was rarely matched by patients, whether they attended or not.

I now turn to describe consulting procedures in the Bafut District Hospital. This was one of the two main clinical settings where I conducted my Bafut fieldwork (the other being the Presbyterian Health Centre at Nsem). When I arrived Bafut on the 13 May 2002 to begin fieldwork, the NCD clinics to care for diabetes patients had barely recovered from nearly two years of limited activity. At the district hospital, there was a building that hosted the diabetes clinic and received both diabetes and hypertension patients simultaneously. A slump in the activities of the clinic had occurred because the clinics previously provided free consultations, blood glucose test and drugs to patients when funded and sustained by the ENHIP project. Clinics had attracted 50 patients. When the project ended, and the free drugs were not available, patients stopped coming. When later the University of Newcastle upon Tyne Medical School resumed their funding, through the ANSA project, the clinic decided to sustain the

drugs and other supplies by charging a token fee to patients. This initiative brought back roughly half of the patients who had earlier stopped coming.

The building in the District Hospital which was initially set aside for the NCD clinic, was partitioned to hold the District Medical Services, its secretariat and the clinic. The clinic served as a corridor to both the doctor's office and the secretariat of the district medical office. Though there was a laboratory in the hospital, all tests and measurements relating to patient management were done in the clinic. One staff member was assigned to run the clinic and to serve as the first contact for all patients. The nurse allowed patients to consult the medical doctors at their request or when he thought a complication necessitated the doctors' intervention. The following extract from fieldnotes gives a flavour of clinic staff interaction with patients:

> Peter and other patients have arrived at the clinic at 7am following the instructions of the nurse. At 8.30am, the nurse arrived, greeted them, then asked them to wait outside for him to clean the consultation room. In 15 minutes he was through so invited the patients into the room, instructing them to respect their order of arrival. He moved out to the out-patient service, stayed for about 10 minutes. When he returned, some patients were already yearning and complaining of hunger. Others complained of the lateness and how they were missing their farms. When the nurse took his seat, he started consulting the patients in turns, doing everything by himself and the patients left with their drugs. Since all the patients were crowded in one room, he spoke like in a whisper asking:
> 'Do you still have some drugs?'
> 'No' Peter replied.
> 'When did they finish?'
> 'Last week', replied Peter.
> 'Why are you coming only today?'
> 'It was not the day that you gave me an appointment.'
> He stopped asking further questions, read through the parameters that he had measured, prescribed the drugs and Peter like other patients left the room.
> (Extracted from fieldnotes in Bafut 17 May 2002).

Patients paid a 500 FCFA (50 pence) fee for FBS to be tested at the clinic but paid full cost 1500 FCFA [£1.50] at the laboratory if they had to be tested for urine. The cost of

drugs was charged in a way that could ensure a regular supply across all the diabetes clinics rather than maximise profits. The price system was set up by the District Health Committee, enabling them to be uniform in all clinics. Even so, their irregular supply only encouraged clinics to subvert matters as they independently sought ways of regularising drug supply.

Eight clinic sessions were held each month, and the patients were spread over these sessions and expected to attend according to their schedule. Though the patients were requested to turn up for consultations very early (at 7am), on each of the two weekly consultations, the clinic staff themselves would only arrive at 8.30am or so, as the extract above shows. Patients noted their order of arrival, while waiting at the entrance of the clinic until the nurse arrived, cleaned the consultation room and started receiving them. During my fieldwork, nurses made attempts to organise group health talks for two months. But this was foiled by the numerous monthly clinic sessions, and the irregular attendance of patients, with some patients turning up for consultations when they were available rather than when they were scheduled. (See figure 11 showing nurse in a clinic in Bafut)

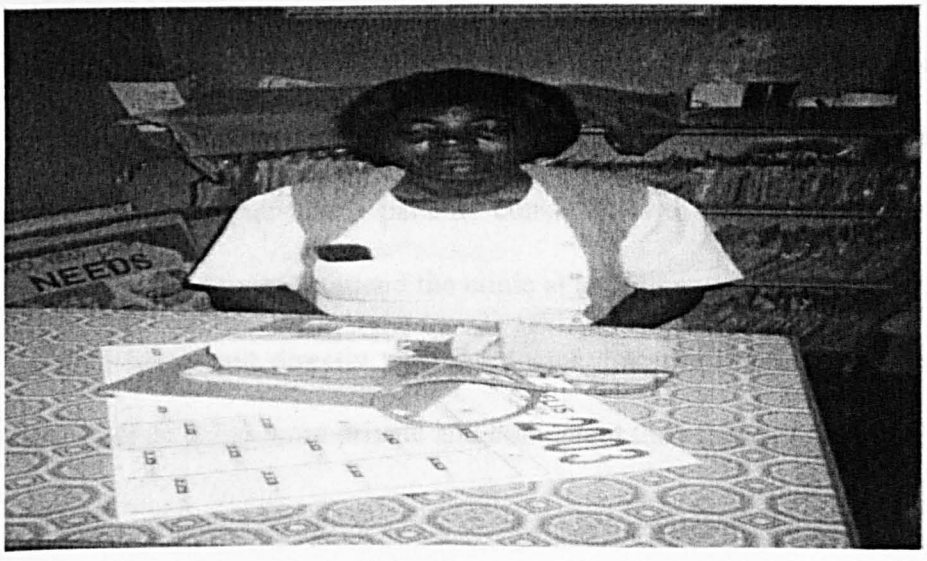


Figure 11: A nurse in a clinic at Bafut waiting for diabetes patients

This made group interaction and management difficult, so such attempts at group health education proved ineffective. Furthermore, the irregular drug supply only exacerbated the irregular attendance at clinics, for such deficiencies made clinic staff appear as failing to meet their obligations. The following quote from a nurse at Bafut reflects circumstances which transpired far more regularly than was ever the case in Biyem-Assi:

> ...There are no drugs. They are out of stock. There are no strips; some which are available are even expired. There are no syringes. As a result when patients come they keep on telling them to go and come later on, some other day or buy from other pharmacies...
>
> (Nurse, Diabetes clinic at Bafut, 7 June 2002)

The clinic staff laid emphasis on individual consultations, using Pidgin English and Bafut most of the time when they answered queries from patients. Many of these queries were about diet and weight gain. Complications were rarely discussed. In particular, sensitive areas like sexual dysfunction were not raised at all, because it remains generally taboo to discuss them in public, and there was no consultation space available for confidential or individual counselling. Every patient's consultation was open to others, something that was widely disliked by patients, making it all the harder to raise matters concerning complications of diabetes considered private and confidential, hence needing intimacy. Since privacy was lacking, the nurse could not do much other than interpret the test results and measurements, prescribe and sell drugs. Some higher status patients consulted with doctors after they had seen the nurse. Others refused to attend the clinic at all, but sought to hide their diabetes status, in order to consult directly with the doctor, because the doctor's consultations were perceived as being more private and competent than those of the nurse (See figure 11).

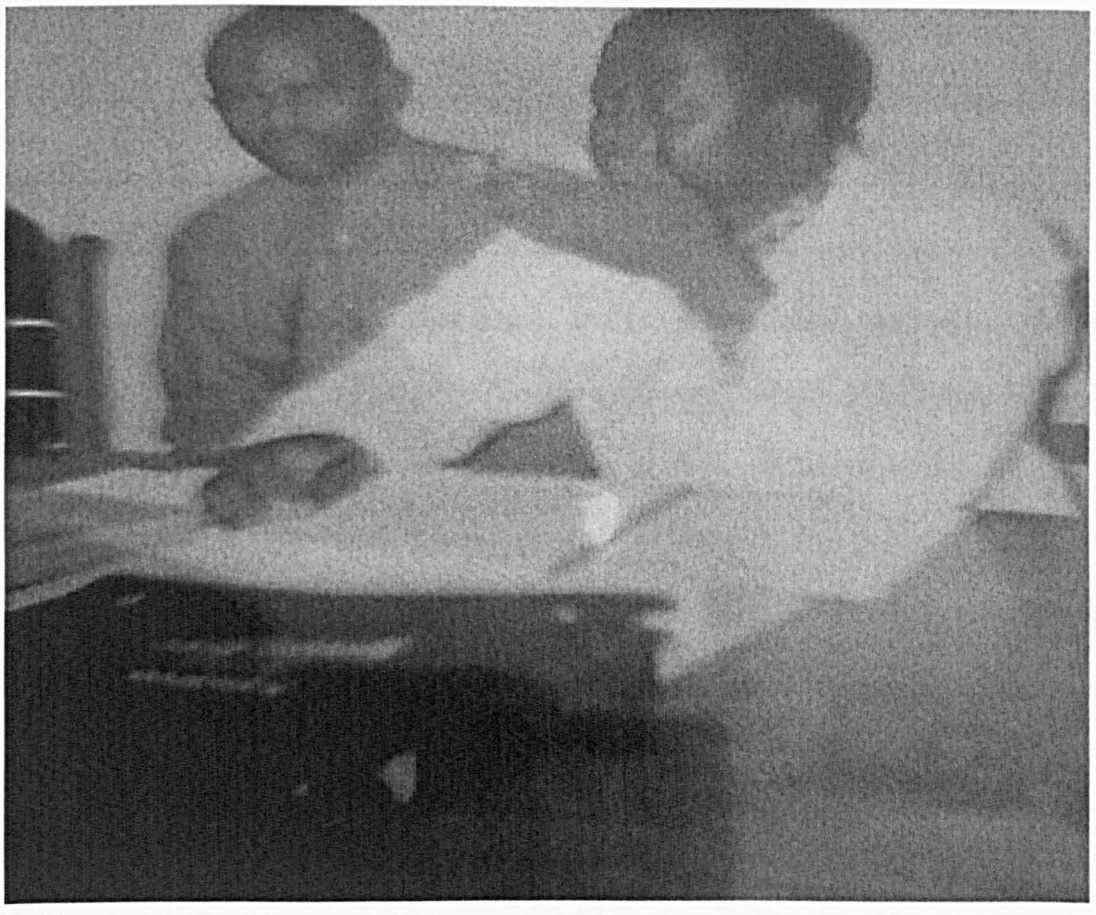


Figure 12: Medical doctor consulting a diabetes patient in his office at Bafut, while I look on.

Overall, the regulations and procedures of the two Bafut clinics were less stringent and rigid than in Biyem-Assi. As a consequence, relationships between clinic staff and patients were generally rather more relaxed, with less of the regimented atmosphere of command and instruction. Clinic staff did not appear as authorities demanding 'compliance' from patients in quite the same way as in Biyem-Assi. On the other hand, procedures would have appeared to Biyem-Assi staff as less efficient and less effective. But it was certainly easier in Bafut for patients to decide whether or not to respect appointments and prescriptions, because fewer sanctions were implied. Patient ambivalence towards a clinical regime of treatment was more overt than in Biyem-Assi, with fewer constraining factors.

Finally, in this section, how much choice did a patient have in deciding where to go for clinical treatment? Though there are other clinics in Yaounde besides those found in Biyem-Assi, these are mainly in tertiary hospitals, where financial and physical access becomes the main constraint. Besides, some of the patients' testimonies about these hospital-based clinics are negative, and their experiences with doctors rather confusing or unsettling, making the "doctor syndrome" less cherished than might be assumed. Bafut does not enjoy a similar range of choices. Some patients go farther distances, up to 50-100 miles, when they want alternatives. But very few people can pay for these trips and consultations. For that reason, patients are confined to the available clinics in Bafut, but tend to switch and alternate between the publicly and privately run institutions.

6.3 Staff-patient relationships

> At about 10 am, I moved from the clinic to the doctor's office to greet and have a chat with him. When I entered, I met him consulting Florence. Florence had just made her round of going to Nsem to check her FBS and returned to the District Hospital to present the results, in order to get the doctor's prescription. The doctor permitted me to have a seat and follow the consultation. The doctor asked if Florence had any problems, and she replied that she was feeling some pains on the back and on her wrist. She also complained of typhoid, gastric pains and malaria. The doctor explained that it was not what she thought. From her records, the FBS had reduced from a very high abnormal level to a reasonably controlled one within a period of three months. She informed the doctor that her diabetes was treated and getting finished, so she concluded that her problem was now typhoid and not diabetes. The doctor enquired about her drugs, 'You were supposed to take Glibenclamide, one tablet each, three times a day and Metformin once'. She looked disturbed and did not utter a word. She tried to argue, and the doctor read out the prescription again. Suddenly he concluded, 'I think I will have to put you again on Insulin. You are not well controlled'. She sat motionless not understanding what the doctor meant. She repeated her complaints to see if the doctor would change his decision, but the doctor did not. She did not want this outcome, so complained that Insulin was not found in pharmacies in Bamenda

> – and even if found it would be expensive. But the doctor replied that the clinic had a consignment of Insulin 100UI.
>
> (Encounter between a doctor and patient, Bafut 14 August 2002, from fieldnotes)

The example here of a consultation between a doctor and a patient, who had been diabetic for many years, offers a clue to some of the difficulties, which keep recurring in relationships between medical staff and diabetic patients. The patient believes her diabetes is almost gone, cured, and gets frustrated at what, to her, is the doctor's unwillingness to look beyond diabetes. For the doctor, the patient is another person who has yet to fully grasp that the problems she brings are symptomatic of her diabetes and the complications that can arise. Although the patient takes time to describe her symptoms, the doctor gives a purely clinical interpretation, quite at odds with the expectation of the patient. This was one of those of older patients who, besides seeking care with nurses, turn to the doctors for more personal and private consultations. It occurred at a time when clinic staff were being encouraged to explain issues raised by patients. Yet this was often like a forced dialogue with clinic staff.

The extract I have quoted above, though it refers to a consultation in Bafut, highlights something that is much more general. For more senior clinic staff, the precepts of modern medicine are almost second nature. These staff can easily be dismissive of patients who, to their way of thinking, 'cling' to the mistaken belief that diabetes can be cured. A good case in point is found in the quote below where a nurse in Biyem-Assi vehemently gives vent to her frustration with one patient.

> ...There is one woman who was suffering from diabetes and she stopped her drugs for one year. When she came back a week ago, I took her book to my chief. She told me that she went to Bafoussam. I told her that there are drugs everywhere. She told me that a traditional doctor at Bafoussam said he will help her not to take drugs all her life and she helped her and she was fine.

> When she came and complained, I told her that these drugs are found all over the country and you can go and take your diabetes drugs from the Provincial Hospital or from the health centre that we run there. As I told you, you have to counsel the patients much. Even when people take their BP on the road, the people tell them that their BP is very low which is not good. Some of them even come back and ask if they can stop their drugs especially when these people on the road deceive them. It is difficult with diabetes because I don't know where they control when they visit traditional doctors. With the hypertension you can control on the road as the boys pass with the machines. Even the weight you can control on the way...
>
> (Declaration of a Nurse at Biyem-Assi, 15 March 2001)

The more senior clinic staff are so socialised themselves into a biomedical approach to health care that they commonly neglect those facets of the experience of illness which might be considered psycho-social. Such staff rarely seem to understand the cluster of reasons that may pull patients away from clinics, and tend to base their understanding of patients' actions only around clinical indicators and measurements made in the clinic setting. Yet however understandable this is, it serves to make their job of communicating with their patients about the many complications of diabetes all the more difficult, for figures and measurements are hard to set in context for most patients. The consequence is that more senior staff and patients have only a very partial grasp of each other's idioms and frames of reference.

Yet for more junior clinic staff matters were not quite so clearcut. Across the clinics in both Bafut and Biyem-Assi, I suggest that junior clinic staff found the comparative novelty of diabetes presented dilemmas for them also. Used to caring for infectious diseases, they were themselves sometimes uncertain about diabetes. Notions of 'treatment' leading to 'cure' were still deeply ingrained in their every day practice. Since clinic staff were used to curing infectious diseases that occur, were cured and

may again recur, many were predisposed to assume all diseases could be completely treated, which meant that they could be cured. In the cultures of Cameroonians, as indeed across West Africa, treatment means curing a disease. The possibility of a disease that has no cure goes against the grain culturally, and whatever training junior clinic staff obtain, introducing them to the aetiology and management of chronic or lifetime conditions that have to be carefully managed at best, innate beliefs about treatment equating with curing are hard to displace entirely. HIV/AIDS has of course profoundly challenged attitudes in this regard (and the ripples of HIV/AIDS in relation to diabetes will become apparent later). But the following extract from a conversation with a relatively junior nurse in Biyem-Assi is a helpful illustration of both a certain level of biomedical understanding coupled with the idiomatic use of the word 'treatment' to assume 'cure'.

> ...Our traditional doctors make announcements over the radio that they treat patients in their clinics. Nobody can really treat diabetes, which is type 1, it is very difficult. No one can treat diabetes. Yet these native doctors say they treat and you get completely well 'cured'. When some patients come back here you see that the blood sugar has risen. It means that the native doctors have wasted all their time for nothing...
>
> (Declaration of a nurse at Biyem-Assi, 21 March 2002)

The very word 'treatment' is thus highly ambiguous in the Cameroonian context, for the way in which clinic staff use the word, and the way in which it is understood by patients are different. Language sometimes seems therefore to accentuate the gap between medical staff and patients rather than helping to bridge it. When diabetes patients talk of treating diabetes, they mean curing it. But treating, to a few clinic staff, means controlling diabetes, with the understanding that it has no cure. The language used by clinic staff is not familiar to and understood by patients.

> ...They doubt what you tell them when you diagnose them. That is why at times when you diagnose them and they are told, they will turn round and say it is a lie. They go away and try to find out from others who tell them wrong things. They receive wrong information and live on that. By the time they return, it is late. Some are even admitted at emergencies with comas. At that time they will talk of witchcraft. They keep wasting time. This is the time that confirmation is done. You then find them coming back here to tell you with a lot of shame that you were right. But some of their organs may already be damaged...
>
> (Declaration of a Nurse at Biyem-Assi, 17 August 2001)

Clinical consultations for diabetes, as for many other diseases, are conducted in a mixture of everyday language and medical jargon. Language related to diabetes often makes things seem more incomprehensible to the patients, most of whom are lay people. The following quote from a health talk, offered by a nurse in Biyem-Assi, is illustrative of how confusion can occur.

> ...If I have asked Papa Jean to talk it because he is old in it. Any person who does not know how to take his insulin it means that we waste time here. We have that magazine there for you to read. Some people have taken them home and do not read it. You have to know how it works. If you don't do it like that about 2-3 times you will think that your medicine does not work. You will think that you are epileptic whereas you are not. Then you will be running here. At times you meet your friends and they tell you wrong things. When you come here you start telling us that you think that it is this or that thing whereas we know what is wrong with you...
>
> (Declaration of a nurse at Biyem-Assi, 21 February 2002)

Too little consideration is made to tailor messages to different categories of patients. This leads to instances of gross misunderstanding, when both the clinic staff and the patients use medical terms. Even where patients strive to understand their condition in biomedical terms, they often appear to arrive at a different understanding of terms and concepts they hear clinic staff using. The quote below illustrates this.

> ...It is funny when you hear people saying that sugar causes diabetes. People think alcohol has not got sugar so they can take it. They don't take soft drinks with the belief that they have a lot of sugar. It is common to see a diabetes patient drinking several bottles of Guinness on grounds that it is medicine to him because it is bitter. Anything bitter is cherished by these people...
>
> (Declaration of a nurse at Biyem-Assi, 21 March 2002)

While the patients refer to diabetes in terms of excess sugar in the body, staff refer to insufficient insulin or absence of insulin. Thus patients use terms in ways which highlight their shortcomings to clinic staff, accentuate barriers of communication between the two sides, and fuel a sense that patients are ignorant.

The more that the gulf in understanding between clinic staff and patients is manifested or maintained, the greater the tendency to passivity among those patients who attend. It should not be assumed that this is necessarily desired by clinic staff.

> ...To me, I like someone who is inquisitive and receptive about diabetes. Many patients just sit and do not want to know more. Such just want to go away and drop the idea. But one who asks a question will help you to explain in a different way, which he understands. Somebody who is receptive is equally good to interact with...
>
> (Declaration of a nurse in Biyem-Assi, 15 March 2002)

But this picture of the good or ideal patient is, I think it is fair to say, only realised in a minority of cases. More commonly, patient passivity enables clinics to process their cases smoothly and as rapidly as possible. Yet staff may not take into account that patient passivity hides various states of mind. Patients may be reticent about direct questioning and self-assertion when they feel wrong-footed by knowledge that they cannot make sense of. They may decide that doing as they are told is to take the line

of least resistance. Or they may in fact harbour a more critical or sceptical mindset, yet be reluctant to be open about this in the clinic setting. As James Scott (1991) argued, in *Domination and the arts of resistance*, when people understand that they are only given passive roles which assume or demand a degree of deference, they may decide to pretend. Scott did not have clinic settings in mind in his analysis, but there are parallels that I would draw here, for diabetes patients I knew and observed getting treatment in clinics certainly knew how to behave in ways which masked their reservations and satisfied clinic staff. To use Scott's terms (1991), every community produces 'public transcripts' (that which is made public) and 'hidden transcripts' (that which is held back), very often for good reasons. Between the hidden and public transcripts, lie a host of manoeuvres and strategies that code, or disguise, what is hidden, and Scott was particularly interested in the ways in which the least powerful create some space for themselves to challenge and resist the behaviour and taken-for-granted assumptions of dominant groups. The diabetes clinic setting proves a fruitful context for discerning the gap between the public and the hidden transcript. What the clinic staff often tended to read – or misread – as docile compliance by largely ignorant patients, masked a more complex and ambivalent set of values and beliefs, including quite a deep-rooted scepticism about the claims and effectiveness of biomedicine, as the next two chapters will illustrate.

To illustrate all this further, clinic staff sometimes themselves seemed confused about their relationships with patients: sometimes believing that they were succeeding in building a sound relationship with patients, while at the same time puzzling to understand the silence and general difficulty they so often faced in getting through to patients. Something of this bewilderment and the sense of the difficulties faced in

communicating easily with patients comes across in the next quote, by a nurse in Biyem-Assi:

> ...At times they may not have confidence in what you say, so they will just be doing theirs. Just things that they are not supposed to do. When they have other information in which they belief, they will be very irregular to the clinic. Something serious [a complication] has to occur first, before they take you seriously. At that time you will see them struggling to comply with what they are told in the clinic...
>
> (Declaration of a nurse at Biyem-Assi, 15 March 2002)

Arising from this situation, I sensed a tendency for medical staff – particularly senior medical staff – to treat patients as child-like. The more senior staff are likely to give a deaf ear to patients' own understandings of diabetes, and their search for explanations for the disease. These understandings, like children's, simply do not warrant proper attention (according to most clinic staff). Medical and lay explanatory models differ greatly in how the two actors in the clinic interpret diabetes, especially its causes, diagnosis and appropriate treatment. Explanations are often based on different understandings of the structure and functions of the body. Some senior staff did understand traditional 'supernatural' and interpersonal explanations of diabetes (explored in the following two chapters), and the definition of good health and social 'balance'; but their training in biomedicine leads them to discount what is taken to be childlike irrational superstition or ignorance. For them, diabetes is manifested and measured in the data provided by the laboratory and through their different instruments, used during consultations. This prevents their considering what characterises patients' opinion and beliefs about diabetes. Senior clinic staff discount emotional states like guilt, shame and remorse, but concentrate only on diagnosing and treating physical dysfunction, as presented by clinic measurements.

Yet the previous paragraph does not entirely reflect the situation in Bafut, least of all among more junior staff. The following extract from a conversation with a nurse during a social drinking in Bafut illustrates one of the more evident contrasts between the urban and rural settings of my fieldwork:

> ...Poverty, the economic crisis has made it difficult for people to obtain medical attention. Some are inherited and pose a problem to be treated. Neighbours or relatives bewitch some people. This is a common characteristic of peasant communities where jealousy, blackmail and slander are the order of the day...
>
> (Nurse in Bafut, 26 July 2002)

In Bafut, it is more common for some of the clinic staff to think like most of their patients think, and to share some of the deeply ingrained cultural assumptions about the underlying causes of all kinds of illness, affliction or misfortune. In this framework, diabetes is not a particular biomedical problem with its own specific aetiology and treatment regime, so much as one of many possible manifestations of misfortune sharing a broadly common social or mystical aetiology.

Furthermore, the situation is rather different in Bafut in another sense also. The hierarchical character of Bafut society, based around the court of the Fon, ensured that a number of patients were not easily discounted socially by clinic staff, whatever their knowledge of biomedicine and diabetes. Traditional forms of status in Bafut society commanded a degree of respect, and some of those with high status could take a high-handed approach to clinic procedures, as a nurse illustrated in these words:

> ...Some of these patients are not serious. They refuse to register in the clinic, yet they turn up to see the doctor privately. These 'big people' [high profile] think that the doctor's consultation is different from what I do. Does he not use

> this same machine? When the doctor is not there, like the other day, they will pretend that they just want to check to see if their sugar is high. When I tell them to buy medicines, they prefer to wait and see the doctor for that. They hide the fact that they have diabetes...
>
> (Nurse in Bafut, 18 September 2002).

Yet as this remark implies, the expectation of respect by high status patients in Bafut is not automatically fulfilled. Within the ambit of the clinical setting, traditional positions do not necessarily count. Certain clinic staff act as though to affirm the superiority of scientific knowledge over local forms of knowledge and belief. Yet most staff are also long-established members of the community they serve. The clinic for them is not a world apart from the rest of their social existence, but embedded within it. Traditional status distinctions have to be recognised therefore. Certain staff indeed themselves have status within this world. Elderly men are called Taa[1] and women Nde[2], in acknowledgement. This certainly helps to create a warmer clinic atmosphere than in Biyem-Assi, where patients are called by their names alone, without any respect for titles. The use of names without any accompanying titles in Biyem-Assi helps to manifest the principle of social equality and opportunity in the clinics. But it also serves to highlight that the status distinction which counts is between the authority of clinic staff and the subordination of patients. In Bafut, that implicit claim is impossible to sustain. In such a face-to-face society, where everyone knows and places everyone else, the wider society cannot be left at the entrance to the clinic, but has to be accommodated – not always easily – within it. When a nurse or

[1] *Taa* means father. Precisely father of. You can call someone *Taa* Ngwa; meaning, Ngwa's father.. *Taa* is a respectable way of calling elderly people. Successors are also called by this title irrespective of their age. If it is a successor, the person is stripped of his name and that of the predecessor used. If the predecessor's name was Ambe, he will be called *Taa* Ambe to signify Ambe's successor.

[2] Nde is the title used to address elderly women and mothers. Since women do not succeed, the issue of succession does not apply with women.

doctor receives a titled person in a clinic in Bafut s/he uses the most socially application title to that person as the quote below exemplifies.

> '*Taa*! Good morning. Welcome. Have a seat. You did not come last Friday for the clinic. Was there something wrong?
>
> (Nurse in Bafut, 15 July 2002)

The above quote is typical of the way that elderly and titled men are addressed in Bafut, especially by juniors. The use of titles in Bafut can create a problem of inequality in communication and care provision. But tension is not great, and is anyway eased because in Bafut observance of titles and proper respect to the holders of titles is important to prevent sanction under the traditional laws of the Bafut Kingdom.

In exploring the issue of titles in the Grassfield kingdom of Nso in Cameroon, Goheen (1996) affirmed that the use of titles is current practice. According to her, people may not use a proper name to address anyone of an equal or higher public status than himself or herself. The finely tuned system of deference by which titleholders are given public recognition is crucial in everyday interaction among people, who know that individuals belong to ranks (Nkwi 1995, Goheen 1996, Rowlands 1998). Yet it is only in rural areas like Bafut that recognition of such titles can be counted on in clinic encounters, for in an urban centre like Yaounde clinics make no such acknowledgement.

6.4 Issue of compliance and non-compliance

> ...You start believing that the patient does not comply to the treatment that you give him. I always feel bad about that... You are frustrated. I mean frustrated, at times when you give drugs, and you realise the drugs and doses are all right, when you check the blood sugar it is even higher to the extent that you can be discouraged. You can even say go and don't come again...
>
> (Declaration of a nurse in Biyem-Assi, 17 August 2001)

Running through all my encounters with medical personnel, in both Biyem-Assi and Bafut, I observed a sense of frustration that most of their diabetes patients readily ignored what was prescribed or advised – in terms of drugs and advice about lifestyle. The phrase I often heard, and the cast of mind that inspired this research in the first place, was that patients would not 'comply'. Compliance was erratic at best in most cases, and sometimes not at all. Frequently, clinic staff said, 'these patients are not complying to treatment'. They meant that patients were failing to adhere to prescriptions when evidence of poor control was apparent in clinic monitoring. But at times 'non-compliance' was generalised and given a moral slant, when used to refer to patients who failed to adhere to prescriptions, failed to turn up for clinic sessions, indulged in alcohol and tobacco consumption, resorted to other forms of treatment [traditional medicine], or failed to follow a prescribed charting of food quantities and spacing of meals. Did people understand this as non-compliance? By no means.

Subjecting patients to disapproval and disparagement or ridicule rarely worked to the clinics' advantage. The next two chapters will explore the question of compliance and non-compliance from the point of view of patients and their families. But the effect of clinic staff using rather casual and dismissive words like *'Wonna'* [you people] was to

fuel the 'them and us' mentality equally reflected on the patients' side in terms like 'these ones', used with a similar lack of respect.

Was 'non-compliance' perceived as a greater problem in Biyem-Assi or Bafut? And among men or women, and younger or older patients? And to what exactly did clinic staff believe that patients should be complying? Routine attendance at the clinic, taking prescribed drugs, or changing dietary behaviour and alcohol consumption? The short answer is all of these. In this widest sense virtually no patient in my study could be seen as compliant. Notions of compliance were undoubtedly articulated more emphatically in Biyem-Assi than Bafut. Yet it was also easier amidst the relative anonymity of the city to articulate a thorough normative framework, a prescribed code of conduct. The paths of staff and patients would not necessarily cross, or would perhaps cross only occasionally. But as the following extract from my fieldwork notes shows, the small scale of Bafut society could easily mean that paths did cross, patients and staff could and did meet socially, and behaviour that was anathema from the clinic perspective could easily be indulged in by patient and staff – together!

> At 12.45 pm, I decided to join some nurses at a bar, opposite the District Hospital. They had taken a break for lunch. Three patients who had been at the clinic to consult that morning were sharing in the social drinking. Some 15 minutes later I was joined by one of the nurses that was consulting this morning. When he entered, there were shouts of 'Doctor, Doctor have a seat here'. He found a seat for himself and was offered a bottle of beer. We continued the social drinking as the beer was distributed in rounds by patients and the nurses. Within two hours the patients had emptied three bottles. I felt that it was too much for them at a time but the nurse offered more, as it was his turn.
>
> (Extract from fieldnotes in Bafut, 4 December 2002)

As we can see here, clinic staff in Bafut may easily at times share in breaching some of the guidelines set out for patients to adopt, to prevent developing complications of

diabetes. This is most evident in the large amounts of alcohol consumed during social drinking. Moreover, several bars are located very near to the clinics, adding to the scope for unplanned but often very easygoing social interaction between patients and staff after clinics close.

On occasions, moreover, the very foundations of biomedical treatment could be subverted, as the following extract from my fieldnotes shows:

> This evening, at 10pm I went to the District Hospital to visit Mary, who had a diabetic coma and was admitted. I stopped at the Nurses' duty room to inform the nurse on duty that I wanted to greet her. The nurse told me to wait for sometime because the family of Mary was 'doing some "country fashion" on her'. When I enquired further, she revealed that it was a traditional healer that was driving away spirits that come and disturb her in the ward. When it was ended I was requested to enter the ward. The room was filled with smoke from incense and the family members around seeming satisfied. One quickly told me, 'These doctors here do their best and since they cannot do everything, we bring the native doctors to drive the witches that put the sick, so that the doctors can succeed.
>
> (Extract from fieldnotes in Bafut, 14 January 2003).

Here we see an example of the nocturnal activities that could on occasions take place within the hospital setting. This is rather more than non-compliance, as envisaged in most clinical comment, for it amounts to an implicit challenge to the claims of biomedicine and clinical effectiveness. Yet for the nurse on duty, this was a matter to turn a blind eye to, something seen as perfectly understandable and perhaps above all familiar in the circumstances of a patient's severe illness (I return to this in Chapter 8). Yet this covert complicity contrasts sharply with the views professed in the following conversation about traditional healers and healing among a group of nurses in Bafut.

> Nurse1. Traditional healers at times they derail people by claiming to treat them but at the end they end up doing nothing. Their role is deceptive.
> Nurse 2. Most of them believe that some of the sick is mystical so they can treat it.

> Nurse 3. Patients believe that their shelter is the native doctor [traditional healer]. The least problem they have they rush to him. I had an experience where a relative was taken to the native doctor and he requested for a lot of money.
> Nurse 2. Witchcraft is what traditional doctors think causes this disease. That is why they feel that everything should be left with them. They say that we cannot help.
> (Extract of conversation with nurses in Bafut, 1 October 2002)

Clinic staff widely believed that women were more likely to observe treatment regimes – to comply – than men. Alcohol was seen as the major factor here, with men's social drinking in bars being hard to put a stop to. But in relation to eating habits also, men were much more likely than women to persist with a diet that they had been advised to change. A common clinic perception was that women were the more likely to listen to and follow medical advice. This discussion amongst three nurses at a social drinking during a lunch break in Bafut reflects this judgement:

> Nurse A: Women respond positively to treatment than men. They comply more. The only thing that disturbs the women is poverty.
> Nurse B: Of course, women keep to instructions than men.
> Nurse C: Men don't take to instructions. They violate the doctor's instructions but the women don't.
> (Extract of a conversation with nurses at Bafut, 19 March 2003).

Similarly, newer patients – those who had been living with diagnosed diabetes for a relatively short time – were thought less likely to follow clinic advice than their counterparts who had lived with the disease for longer. Experience inevitably brought some kind of adjustment, for the patient who had survived with diabetes for a significant period of time was almost by definition one who had learned that there was no secret cure for the disease, no alternative to learning how to manage it, and no alternative to controlling their fasting blood glucose (FBG). Thus the commonplace frustration – so evident at least among clinic staff in Biyem-Assi – with patients' lack of compliance was focused especially on 'newer' diabetics, those who were still

learning to manage their diabetes. 'Older' diabetics who failed to follow clinic advice either did so periodically, before getting themselves back on the rails, or else would in due course fail to survive.

The most common complications of diabetes that clinics sought to deal with were related to retinopathy (visual impairment), sexual dysfunction (erectile dysfunction), neuropathy and hypertension. Yet while clinic staff understood these complications to arise from poorly controlled diabetes, this was not the same with patients. Patients were prone to attribute these complications to the intervention of an external agent, in the form most typically of a witch or an ancestor (see following chapters). Even where mystical aetiology was not invoked as an ultimate cause, clinic staff often struggled to persuade patients that these distinct symptoms were not evidence of an unrelated health problem, but were directly a consequence of the diabetes.

The biggest issue with regards to compliance, related as much to conflicting ideas about the causes of diabetes as its treatment. To put it another way, conflicting ideas about the causes of diabetes presupposes differing forms of treatment. The more patients continue to hold that diabetes is a curable disease; the more likely they are not to be persuaded by medical staff insistence on compliance with their regime of treatment, and to seek out traditional healers of one kind or another (see Chapter VIII). Thus the problem of patient compliance leads, via the idea that diabetes is a curable disease, to the continuing influence and importance of traditional healers and their practices. While medical staff are often sympathetic to the financial pressures which might make compliance difficult for those with few resources, they are not at all sympathetic to patients who turn to traditional healers to supplement the clinic's care.

It is worth saying here that for some senior clinic staff the recent effort on the part of the Ministry of Health in Cameroon to attempt to integrate certain traditional medicine practitioners into the health care system has met with anger and disbelief. I have sought to illustrate the vehemence of the disdain felt by senior clinic staff towards traditional healers. Yet at the same time the Ministry of Health has decided to give traditional healers some limited political recognition and legitimacy, in an attempt to draw the more 'reputable' among them into wider debate and consideration about the country's health problems and coming health care needs. For the more senior clinic staff, this concession is tantamount to encouraging patients to flout clinic guidelines and advice. It is seen as lending legitimacy to the very practice of patients' mixing consultation and treatment in both traditional and biomedical settings which clinics strenuously deplore.

My discussion so far has suggested a profound gap between clinic staff and patients. I want to end this chapter by qualifying this impression in certain important respects. While broadly true in the case of senior staff, it is important to remember that there are many more junior staff whose knowledge about diabetes, and information about appropriate treatment, is much sketchier. Moreover, these clinic staff are not somehow detached from the communities they work in, but very much a part of them. They share the wider values and assumptions to a considerable degree.

And if diabetes is for many Cameroonians, a relatively 'new' disease, so it is new for staff too – particularly in Bafut, where staff typically have less knowledge than in Biyem-Assi. The sparse knowledge about diabetes amongst staff in Bafut is due to their lesser exposure to modern information technology, lesser participation in

information update seminars and workshops. Television signals, the cheapest way of gaining additional knowledge about diabetes, are not received in most of Bafut. The print media and the Internet, by which staff can also acquire more knowledge about diabetes, are completely unavailable. It was to be expected that the situation would be different in Biyem-Assi where such services are abundantly available and cheap.

6.5 Conclusion

The role played by context is very important in clinic diabetes care. Two aspects have been revealed by this ethnography. The first is the internal context of the poor experience, expectations, cultural assumptions, explanatory models and prejudices (based on social, gender, and ethnic criteria) that each party brings to the clinic encounter. Secondly, there is an external context, which includes the actual setting in which the encounters take place (such as the clinic or doctor's office or the hospital), and the wider social influences acting upon the two parties. These include the dominant ideology and economy of the society where they operate, as well as its class, gender or ethnic divisions. All these factors help to show that clinic staff have power and authority in the consultations. Of key importance, here, is the role of economic and social inequalities – the differences in power, particularly between doctors and patients. These two types of context greatly influence communication between clinic staff and patients. They determine what is said, how it is said and how it is heard, interpreted and acted upon.

Diabetes, though portrayed in the clinic as a biomedical phenomenon, is not for those who suffer from it – and their families – reducible to its biomedical characteristics. It is also a social issue, with all the dynamics that go with that. Clinic staff are playing just one of the roles that Cameroonians currently tend to recognise in the treatment/ healing process. However, this opens the gateway into the social world at large, where the others [patients, families, traditional healers and other members of the community] exist and understand diabetes, in a context quite different from that of the clinics. In these wider social milieux, the same actors construe diabetes in their own fashion, drawing ever more on the ideas and practices of biomedicine, but also going well beyond these, to draw in ingrained beliefs and assumptions which get labelled even by modern Cameroonians as 'traditional'. The clinic perspective of diabetes is not by any means the end of the story, as the two following chapters will show.

Chapter VII

'If they were not there, we would have died'. Patient and family perspectives of diabetes

7.1 Introduction

> ...I cannot believe what the people in the hospital told me. It was just exactly what the native doctor told me. They told me that the level of the sugar was very high. At the hospital those nurses tried to tell me that it might be because I had a lot of weight [obese] and that I should reduce it. I have already lost weight and they still want me to do so. Some people were already thinking that I have AIDS. This is not how I used to be. I will just finish these their drugs because I bought them. But tomorrow, I will go for more protection and tell the native doctor that he is a man. He knows his job. I don't have to joke at my workplace because there is a lot of witchcraft and jealousy there; else I will go [die] and leave my children and my wife. They (people at the workplace) have put this diabetes into my body. My family told me in the village that I should be careful. So I don't have to joke about it... You see, I have to live like this from now hence. My man (traditional healer) will cure me and that enemy will be ashamed...
>
> (Stephen, diabetes patient in Biyem-Assi, 23 September 2001).

The above quote is from a conversation with Stephen, a police officer newly diagnosed with diabetes, in Biyem-Assi. It highlights some widely held attitudes, and reveals some of the actions that patients and families of people living with diabetes undertake in response to its initial signs and symptoms. This chapter explores these themes, and attempts to answer the following questions. What understanding do patients and their families have of diabetes? How do they describe it? How do those with diabetes cope with it, and how do their families help to manage diabetes and its complications? And how do patients and families deal with alternative frameworks of knowledge about cause, care and cure in the context of diabetes?

The chapter starts by presenting popular or 'lay' explanations of diabetes (7.2). As I will show, aetiologies and taxonomies of diabetes draw on both biomedical and traditional medicine, the latter particularly strong whether in Bafut or Yaounde. But beyond the terminology in use, two main lay viewpoints stand out in this section: firstly that the 'causes' of diabetes are widely seen to be ultimately social, and not

purely biomedical; and secondly that diabetes is widely seen as a curable disease. These two assumptions shape the actions taken by patients and their families (7.3). Family support is examined, including different encounters and conflicts concerning nutrition, sexual activity, and social adjustment. I also look more widely to illustrate where the wider community becomes involved. I then go on to examine how families help to manage the complications arising with diabetes. Finally, the issue of 'compliance', one of the main themes of this ethnography, is examined from the perspective of patients and their families (7.4). This discussion draws in notions of vulnerability and disobedience. In each section, I compare the evidence relating to the two study settings, in order to draw out similarities and differences.

7.2 Popular understandings of diabetes

> ...My son, my own diabetes is not natural. It was put in me through witchcraft. I have been suffering from this for years. I cure and it comes back. I saw one native doctor who found out (in that their way - divination) and told me that my own diabetes is made. He assured me that it is easy to cure. He asked me to bring some things so that he should prove to me that it was put in me. He revealed that the relatives of my husband made my diabetes because my husband had a lot of property, and when he died he left them to me and I am enjoying with my children... They (My husband's relatives) put tiger hair into my stomach and the tiger hair provokes the diabetes. When I took those things to him (Native doctor), he removed the tiger hair and showed me. When he removed it I slept very well. Since he forgot to protect me from being sent the diabetes again, they (My husband's relatives) sent another one. He has removed it and protected me in a way that they will come back and it will bounce back to them. I go to the clinic all the time to see if the diabetes has come back and the doctors there also give me medicines...
>
> (Monica, diabetes patient in Bafut, 23 October 2002).

In the previous chapter, I examined the power of clinic staff to transform the knowledge and understanding of diabetes patients about their disease. But I also highlighted the obstacles faced by clinic staff, and the resistance they met. Not overt

resistance by any means, but a reluctance to be convinced by the advice and treatment they received, which severely limited the effectiveness of the clinics I did fieldwork in. Moreover, the financial costs of adhering to clinic advice were also a factor, adding to this resistance. This section begins to explain this reluctance, by exploring beneath the surface of lay understandings of diabetes. I examine questions that were commonly asked. What has happened? Why has it happened? Why has it happened to me personally, and at this time? And what can I do about it? To begin with, I will discuss the naming and taxonomy of diabetes.

In his ethnography, Robert Pool (1994) started from a biomedically defined syndrome (kwashiorkor) and sought to understand how this disease syndrome was defined, located and interpreted in the thought and practice of the area of the Grassfields where he worked. The process of doing justice to this local knowledge meant casting aside the parameters of the initial syndrome altogether. The boundaries of what is or is not kwashiorkor disappear in this perspective. Similarly, I have started with a biomedically defined disease category – Diabetes Mellitus – with all that is associated in terms of its aetiology, treatment and prognosis, and have sought to understand what those I knew in Bafut and Biyem-Assi understood by diabetes. This has, likewise, meant moving beyond the biomedical classification of a disease. Not only does this involve a shift from a focus on a disease but also to a focus on the experience of illness. As in Pool's case, though probably not to the same extent, my enquiries also redefine the boundaries of diabetes. It is not only a matter of saying that diabetes 'means' something different in Bafut – and something slightly different again in Biyem-Assi. It is also that these different meanings reshape the nature of the supposed entity in question. Thus there is not an indigenous category of illness or disease that

occupies the same space as 'diabetes' in biomedicine. I shall start by discussing names, taking Bafut as an illustration (the linguistic diversity of Biyem-Assi makes an equivalent outline too complex to summarise, although the principles at stake are similar).

While the word 'diabetes' is often used (and there in itself is a significant contrast with Pool (1995)), so also are a number of indigenous words. At a social drinking, some patients attempted all the possible ways of naming diabetes as the following quote amplifies.

> Ambi. 'We call diabetes *Nighoni-shugar*.'
> Sammy. 'It means sugar, sugar sick.'
> Peter. 'With the word sugar, in Bafut, this is just a new thing that we have inherited from the medical department. We call it *Kweeh, Kukwée* to mean an illness that originate from sugar and too much sweet things.'
> Pastor. 'From the traditional point of view we did not have diabetes. It has been unknown to us. It might have been there but unknown to us. We call it *Nighoni-shugar*'
> Sammy. '*Fumbgwuang, Nshugar* is how we commonly call it. It is *Nighoni-Fumngwuang*. Otherwise, we call it *Nighoni-shugar*.'
> Peter. '*Nshugar à sesang*.'
> Ambi. '*A sefune Leleh*.'
> Peter. *Fumbgwuang ghanée*.
> (Extract from a conversation with diabetes patients in Bafut, 20 January 2003).

None of these can be taken as a straightforward equivalent for diabetes. Out of a number of terms in use in Bafut, two key words, *fumbgwuang* and *shugar* are most frequently heard. These are used along with *nighoni*. *Nighoni-shugar* denotes 'sugar diseases' and *nighoni-fumbgwuang* 'disease that is sweet'. Thus one refers to a food product, the other to taste, with *nighoni* meaning sickness or illness. Yet, while *shugar* is sugar, *fumbgwuang* means salt, as well as referring to a sweet taste, a taste that goes wider than the sweetness associated with sugar. Thus salt and sugar are

associated with diabetes. But perhaps most relevantly, the disease is seen as linked to an indigenous sense of sweet taste, which encompasses the more familiar salt. In this manner, diabetes is the illness that comes from sweetness and the illness coming from sugar. If a person suspects that he may be ill from this disease, a common way to diagnose it himself is by tasting his own urine. When one urinates frequently and suspects that something is wrong, so one samples one's urine. If it has the taste of sugar, or tastes sweet, then a person suspects *nighoni-shugar or fumbngwuang.* Indeed, individuals who are already being treated for diabetes sometimes use this method to control their blood sugar levels, especially when they lack the means to do it in a clinic.

Urinating also provides another clue to self-diagnosis. People urinate wherever it is convenient. If, when one urinates, one then finds that ants are visiting the spot to feed on the urine, one is likely to conclude that one suffers from *nighoni-fumbngwuang.* People relate that observation to their observation of ants when they crowd around deposited particles of salt or sugar. Whereas diabetes mellitus conveys little about the signs and symptoms of the disease, the two indigenous terms are grounded in the experience of the person afflicted – the experience of illness – and also suggest crucial things about the underlying mechanisms of illness and its origin. These interpretations help patients and families to make some sense of what diabetes means for the body. Yet I also note here that urination can be ambiguous as an informal diagnostic tool. For urinating frequently is also said to be a way of washing out sickness, and therefore, a sign of getting rid of a source of ill-health, rather than as a clue to an emerging health problem.

But it is important to emphasise that these ideas and responses are not static or unchanging. As I have mentioned, the term 'diabetes' is widely used. Indeed, as more and more patients are clinically diagnosed, the word diabetes becomes increasingly part of common currency in Bafut as much as in Yaounde, and may well in due course completely supplant the local terms discussed above. Nevertheless, when people were asked to explain what they understood diabetes to be, it was the local terms and their connotations which were most readily called upon. In this way, diabetes is still most commonly understood and made sense of by reference to traditional or pre-existing ideas. The use of the word diabetes cannot be assumed to mean that the user thinks of diabetes as clinic staff might hope. Nonetheless, over time, that may be expected to happen. While I have discussed the connotations of the two popular idioms used in describing diabetes in Bafut, there are other indigenous terms and descriptions which are nowadays fading from use: *yoongkee* and *ki-yoongkee*[1], for example. I would not be surprised if, one day, *shugar and fumbngwuang* are replaced by diabetes, to be called *nighoni-diabetes*. Terminology, and the understanding of that terminology about diabetes, is thus constantly evolving.

How much is changing? Though people remain faithful to traditional cultural values about the causes and treatment of diabetes, several changes are apparent. Firstly, the naming of diabetes has moved from purely traditional appellations to a mixture of local languages and English or French whereby high sugar in the blood is associated with diabetes. This calls for the use of local language words as prefixes, '*Nighoni-Shugar*' by Bafut people, '*Wou-Sukar*' by the Bafang and many others. There is every indication that the more signs and symptoms of diabetes are acknowledged and

[1] *Yoongkee* or *Ki-yoongkee* is an illness description in Bafut where one's blood becomes water and one develops swollen feet and stomach.

accepted by people, the more the names will evolve and the local prefix may eventually fade and be forgotten.

To what extent will the next generation of diabetes patients deal with these choices and pressures differently? It will take quite a long time for people to come to terms with the fact that diabetes has no cure. All the more so because people stick to many of their cultural values even out of their motherland. Even many of the educated elite are unlikely to give up the ingrained assumption that someone must be responsible when ill health strikes. So far as most people remain poor and are unable to receive good quality education and health care, then entrenched beliefs are likely to persist.

Where does diabetes come from? The following quotes illustrate common understandings of the source of diabetes by people in Bafut and Biyem-Assi.

> ...My diabetes was caused by beer. I was drinking sweet beer called *Shandy*. I could sit at a time and take eight bottles. I was advised against that but I did not know. They would say, "as you are drinking beer like this you would soon develop diabetes". I didn't know what diabetes was. I started drinking glucose. I started urinating very frequently, but thought that it was a way of cleaning my system. I started taking Bournvita[2]. I didn't know that I was adding sick, until when this thing (Diabetes) was discovered. I tried to get some advice and treatment. I tasted my urine and it was sweet like sugar. I think that my own was caused by myself...
>
> (Sammy, diabetes patient in Bafut, 17 September 2002).

> ...My doctor said that too much sugar in the pancreas cause diabetes because the sugar is not well used in the pancreas. So I think that excess sugar cause diabetes...
>
> (Dongmo, diabetes patient in Biyem-Assi, 11 March 2002)

> ...I could urinate about eight times a night. I did not know until I tasted a sample of my urine and it was as sweet as sugar...
>
> (Jean-Pierre, diabetes patient in Biyem-Assi, 4 April 2002).

[2] Bournvita is a beverage, usually taken as a supplement of tea.

These comments highlight the tell-tale importance of one's urine. That urine tastes sweet means that a person has the 'sugar illness'. The sampling of urine, either through its taste or by its foaming after urination or visitation by ants, were back-ups for fasting blood glucose (FBG) test in the absence of money to pay for the test. When patients do this, it enables them to measure qualitatively the magnitude of FBG without resort to figures or clinics. They can stay home until they have enough money to attend the clinics. In other instances, some patients turn up at the clinics when signs and symptoms of discomfort resulting from diabetes are 'confirmed' in urine. We see here the ability of some patients to self-monitor blood glucose by this method. Others alluded to a further step that can be taken with one's urine, going beyond its value as a diagnostic aid and suggesting its therapeutic potential. 'Urine therapy' – collecting and drinking one's own urine in the belief that it can be an effective treatment for diabetes – was not mentioned by any patients I spoke with, but nonetheless it was quite widely mentioned. It would be hard to gauge how widely it was put into practice.

Naming an illness or disease is only a first step. Yet, in seeking to understand popular understandings of causation, the names ascribed by people offered certain clues. Sugar and sweet things in general seemed to be one of the causes of diabetes that people highlighted and understood, reflecting how the language of 'high sugar level' (hyperglycaemia) in the clinic found its way into popular idioms. In both settings, many patients often declared when I enquired that 'I know that diabetes is caused by eating a lot of sweet things'. This kind of causation places the 'blame' or responsibility on the individual for excesses in eating and drinking, and most patients by and large realise that this is the implication.

From the clinic perspective, it might be thought so far so good. Yet, this is only one part of an explanation, and whatever the chain of cause and effect, internal to the body of the patient, there are usually also chains of cause and effect, external to the patients' body, which are seen as more important, as the case study below will illustrate.

> John, a retired civil servant of 65, went into a diabetic coma and was admitted at the Bafut District Hospital. He was a patient already known for hypertension and as alcoholic. He had been complaining of dizziness, thirstiness and frequent urination. He was diagnosed with diabetes. As a 'successor' of a very big compound, appointed after the death of his father, his older children[3] clustered around, offered Christian prayers and performed sacrifices to the ancestors so that the doctors should restore him to health. While the nurses were doing their part to restore him, his family went to consult a diviner. This diviner told them that the ancestors were unhappy with him and had decided to punish him. A consensus was reached on how the ancestors had to be appeased. When John recovered from the coma, he was informed and was amazed at the turn of events. However he admitted to me that there was a rite that he ought to have performed in his father's compound which he had not done since he was enthroned. Moreover at the time he told me that he was not predisposed to having diabetes in consequence of the risk factors explained to him by the nurse and the doctor who treated him. He assembled his children a few weeks afterwards, performed the stipulated sacrifices to the ancestors and fed the family. However, as time went on John became more familiar with diabetes and the language of the clinic staff. But he kept mixing traditional medicine and insulin treatment, and armed himself with traditional protective bags stocked with ground leaves to ward off any threat from witches.
>
> (John, diabetes patient in Bafut, 17 January 2003)

The example above suggests three distinct frameworks within which to think about both the causes and the treating of diabetes, of which two bear no relation to biomedical knowledge but address the problem of cause at a different level altogether. In this extract, we see a man and his family moving between biomedical causation (and acknowledgement of the role of personal 'lifestyle' and diet), an idiom of ancestral causation, and an idiom which identifies malignant intentions by fellow living human beings, in the form of witchcraft. Although I should stress that people

did not use the following categories, which are my own, a three-way distinction was often implicit between what I might call 'natural' (i.e. lifestyle-induced) diabetes, 'ancestral' (i.e. ancestor-caused) diabetes, and 'man-made' (i.e. witch-induced) diabetes, reflecting the salience of alternative, but often elided, explanatory frameworks. This was as true of Yaounde as of Bafut.

In relation to the first of these frameworks, some people recognised that sweet food, sweet beverages, smoking, fatty food and lack of physical activities could predispose to diabetes. Yet there was a significant ambivalence here too. While a few patients and their families understood that obesity could cause diabetes, most also saw that as a sign of good living. It was common to hear some patients regret, 'I used to be fat and weigh 100kg but this sick has made me to grow dry'. Or some people would say, 'I feel that I am a man when I am fat. When you start losing weight, people think that you have AIDS'. Family members shared this opinion, as was typified in the comment of one person that 'it is good he should die resembling a man than dying looking like somebody with AIDS.' Many of the patients and families in this study struggled to come to terms with the idea that diabetes patients should lose weight, when this was simultaneously seen as a kind of diminution or disfigurement. These concerns are compounded in the present context because of HIV/AIDS. For dramatic weight loss has also acquired particular connotations, which have accentuated resistance to it, for no one wants to be thought to be losing weight because of AIDS.

In relation to the second of these frameworks, across the Grassfield and many other areas in Cameroon, ancestral punishment, by way of illness has pride of place in people's understanding of why illness strikes one person rather than another at any

[3] Brothers and step brothers whom he had inherited from the father as his successor.

time. For this reason, most people regularly perform rituals to sustain their ties with their ancestors. Among some ethnic groups in the Grassfield, the supposed whereabouts of the ancestors is vague (Gufler 2003, Zeitlyn 2001); in other cases, ancestors are thought of as having identifiable dwelling places (Pool 1994). But in either case, the capacity to manifest themselves and their anger through causing misfortune among their descendants is agreed (cf. Feldman-Savelsberg 2002, regarding infertility). My ethnography emphasises how strongly Bafut people regard ancestors as remaining alive after death, but out of sight, a vital presence caring for the family, watching and inspecting to ensure harmony and punishing defaulters. In Bafut, moreover, 'missing' (dead) *Fons* and important elders who have died, become ancestors with extended powers to oversee life in all families. So powerfully ingrained are notions of ancestral oversight of the world of the living that they are considered to be the supreme actors in daily life. The existence of Christianity has impacted on these beliefs in the sense that the two religious frames of reference coexist side by side. But Christianity has in no sense weakened beliefs and practices surrounding the ancestors in Bafut.

However, it will be wrong to think that this state of mind and belief is exclusively that of Bafut and other Grassfield areas, for much the same is evident in urban centres like Yaounde also. In Biyem-Assi numerous diviners and ritual specialists abound, though local knowledge of the credibility and repute of individual practitioners may be more limited than in rural areas, and subject to more caution and testing by their potential clientele. Yet in the same way as in Bafut, such urban practitioners point out ancestral causes of diabetes and advise people to return to their villages for rituals as a necessary prerequisite for the effective cure of their diabetes.

Ancestral interventions to 'cause' diabetes are not always thought of as being attributable to recent oversights or human failings. When a person within a family develops diabetes, a diviner may trace the precipitating problem back for several generations, perhaps even a century or more. What is construed in a clinic now as a family history of diabetes may ironically also be interpreted by a diviner as a kind of family inheritance, created in this idiom by an unrealised and unresolved problem, dating several generations back. Diabetes in this way becomes an expression of something else.

> ...When Ambe, in Bafut, aged 42, was diagnosed with diabetes, his family consulted a diviner, who concluded that the cause could be traced back to an ancestor (a great great grand mother) who had been married to the *Fon* [King] without any bride-price being paid. This marriage occurred more than a century ago. The anger of the ancestors against the bride's family for failing to obtain the bride-price due had precipitated the introduction of diabetes into Ambe's body. Family members today could only remember that one of their relatives had been married to a *Fon* several generations ago. But they sought a token bride-price from the current *Fon* (who himself did not know of her) to restore relations with the ancestors...
>
> (Ambe, diabetes patient in Bafut, 12 November 2002).

Explaining the cause of diabetes to be due to the influence of ancestors meant revealing a problem that needed to be resolved, whether that was a problem previously known or unknown to the affected family. The revelation of the diviner in the illustration above helped to affirm the diabetes status of Ambe, and led to a 'resolution' through the token bride-price paid by the current *Fon*. The causing of diabetes by ancestors, in this instance like many others, can be understood as a means of relaying information by the weak to the powerful, using the ancestors as a neutral platform. The idiom was one which everyone in Bafut could understand and accept without feeling accused or hurt. If that were not the case, the *Fon* and his council of

elders might have interpreted the suggestion as an insult, resulting in the family of the bride from long ago being fined. But ancestral invocations and declarations are treated simultaneously as emergencies and truth. In one sense we might construe this framework of belief in terms of Scott's (1991) idea of 'weapons of the weak', a source of power available to the relatively powerless. Yet that would overlook the consensual basis of such declarations, making it unhelpful to cast within the framework of 'resistance'.

What is important to stress here is how much the linked events of death and succession mark a transition that is crucial to an understanding of beliefs about ancestral influence in the appearance (or 'reappearance') of diabetes. One of the several ways of appeasing and coming to terms with ancestors is at a person's death, through *cry-die* [death celebrations]. This practice is not restricted to Bafut, but cuts across ethnic groups in Cameroon. In the more centralised Grassfield Kingdoms, like Bafut, death celebrations differ depending on the age and status of the deceased, and in the case of men particularly the titles he holds and the associations to which he belongs. Age, gender and titles make a difference in the duration of death celebrations. For example the death celebration of a *Fon* [King], a *Maa-Nfor* [Queen mother], *Muma* [direct assistant to the king] and an *Atangcho* [village chief] in Bafut, just to name a few, take a week or more, but those of ordinary title and non-title holders take a maximum of three days. With the case study of Samuel in Chapter V, I illustrated how the Church and traditional authorities collaboratively participated in the organisation of his funeral. Again in one of the death celebrations (see figure 13 and figure 14) in which I was involved because a neighbour was an in-law, there was an

elaborate display of status and hierarchy because these people were linked to the palace and held traditional titles.

Figure 13: Dancing at *Nsan-Manji* during a death celebration in Bafut

Figure 14: Women in Yaounde displaying during a death celebration

Yet whether you hold a title or not, an overriding obligation is feeding people to the extent that they will not require further food and drink. The following remark alludes to the importance of feeding to excess.

> ...We eat, go out and vomit some of the food and *Mimbo*. If it cannot go out of the stomach, we drink *kannwa soup* [soup prepared with limestone] and your eyes become clear again then you continue...
>
> (Declaration of a participant at a death celebration, Bafut, 22 March 2003).

A failure to organise an appropriate death celebration after the death of a family member, and most importantly failing to feed people well, were commonly seen as reasons why ancestral intervention might lead to diabetes as a 'punishment' for such vital neglect. Consequently, death celebrations were one key to the prevention of diseases like diabetes. The relationships which exist between people and which are supposed to inform everyday behaviour become visible at the performance of illness and death related obligations. Failure to feed people during a person's death celebration places the family under the potential wrath of the ancestors, who may get angry and holdback treatment or may punish with a chronic disease like diabetes. Moreover, in families already struggling to cope with a diabetic member, death celebrations were often done at the expense of pending care needs, partly on the grounds of cost at a time when no expense should be spared in meeting wider social obligations, and partly also because a widely held belief was that a successful cry-die will in itself lead to a cure.

Just as important as the correct observance of *cry-die* largesse was the correct observance of succession where appropriate in the case of men. In Bafut, this means getting a *Nzinda* [successor] to the dead person. This successor may take up the position of a lineage head[4]. The succession decisions follow the will of the dead father, which may be written or verbal. In the absence of a will, a random choice is made

[4] The lineage head is the economic, political, and spiritual leader, the big man, of a group belonging to up to five generations in depth or more.

amongst the youngest sons, though there is a preference for installing the last son. Elder sons are not often installed as successors. If there are no male children alive a grand son may be installed as a successor, or failing that a sister's son. A grand father may take this decision before dying. When the family agrees, the prospective successor is taken to the palace for succession and initiation rituals to be performed, after which he is permitted to act as a successor, and to represent the family in all activities of the kingdom.

That is the theory. But quite often these principles get subverted by the most powerful, who declare and install themselves as successors. In Bafut, respecting the dead person's decision is a way of remaining on good terms with the ancestors. But diabetes is seen as one of the diseases which may be 'sent' by ancestors to punish defaulters of succession decisions in the family. It was no coincidence that many of the patients that I came across had backgrounds where succession conflicts had been a topical issue. Equally, this was by no means confined to Bafut and the Grassfields, for the same ideas were common among patients I knew and heard about in Biyem-Assi also. The 'mistake' could only be rectified by installation of a rightful successor, for in that way ancestors were appeased. And in that way also were diseases like diabetes believed to be 'cured'.

Third, we come to witchcraft as a widespread explanation for diabetes (among a long list of chronic health problems potentially attributable to the action of witches). This might be represented in several ways:

> ...My diabetes was caused by witchcraft. A witch had sex with me while I was asleep. Since then, I developed a malaise until I was diagnosed with diabetes.'
> (Jacob, diabetes patient in Bafut, 31 August 2002).

> ...My friend sent this diabetes to me as *Musong*, just because he was jealous of my progress...
>
> (Prosper, diabetes patient in Biyem-Assi, 12 December 2001).

The first remark highlights one of the commonest ways in which people assumed that they might be vulnerable to witchcraft, namely through sex as a route of transmission and an idiom of the body being breached (for men and women). If sex was one very common route, poisoning of food (through poisoning of crops or the addition of poisons to cooking) was another, and here again the idea of ingestion provides another idiom of the body being breached. By contrast with some other ethnography from the Cameroon Grassfield, my ethnography suggests that the victims of witchcraft may not necessarily be close consanguineal kin of those who are divined as seeking to harm them. Monica's experience provides a case in point.

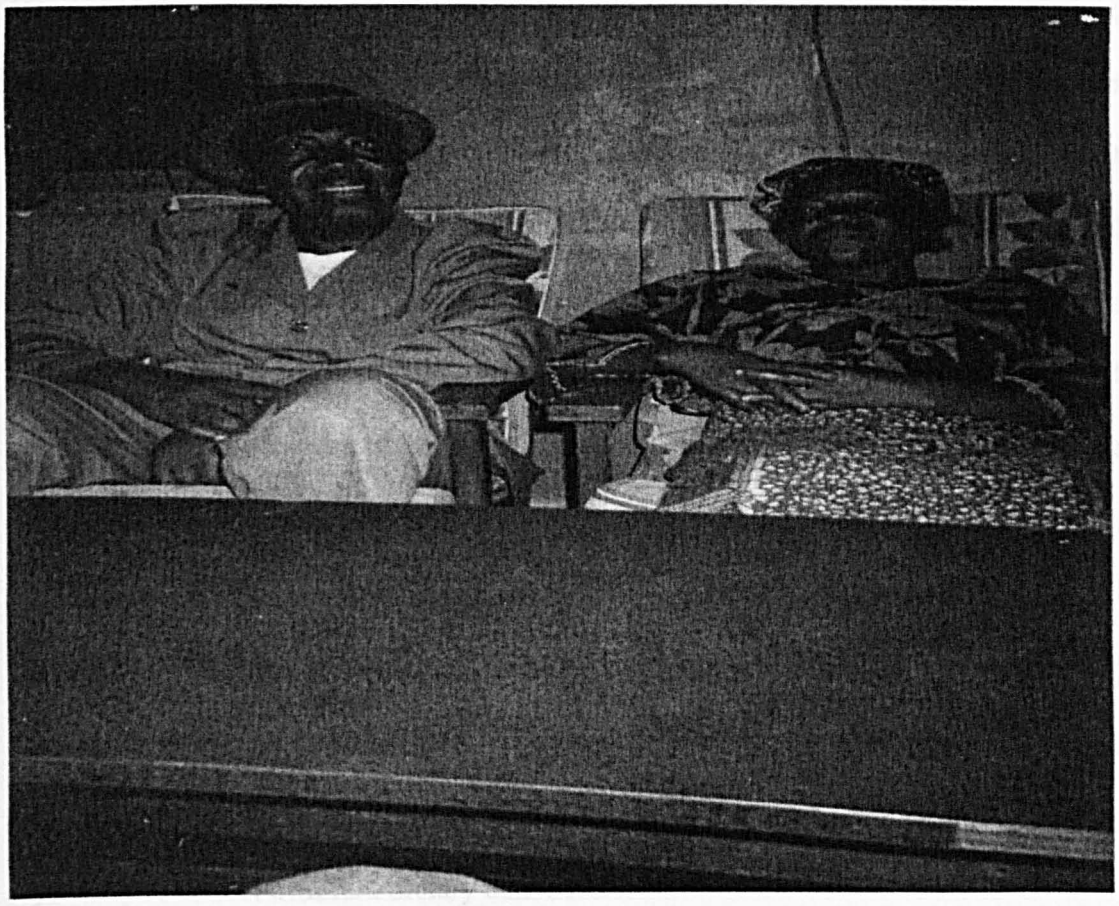
> Monica, in her late 60s, had been diagnosed in the clinic with diabetes, but she turned to a traditional healer, with divining skills, to obtain an explanation why she had diabetes, a disease unknown to her. The diviner explained to her that she had been a victim of witchcraft, whereby tiger hair containing diabetes was shot at her in the night, when she was sleeping and this stock in her stomach and was causing her to have diabetes. After a long explanation, and with the help of Monica, the accused were identified to be her brothers-in-law.
>
> (Extract from fieldnotes, Bafut 5 March 2003)

Though Monica was in this case believed to have been 'bewitched' with diabetes by affinally-related members of her family, many other patients believe that witchcraft may come from outside the victim's family altogether. Various more or less articulated beliefs about the capabilities, reach and intentions of witches abound. But in general, it is thought unfortunate if family problems become common currency outside the family, and one explanation given was precisely that this increased family vulnerability to witchcraft. But this attitude itself endorsed the possibility that the source of a witchcraft attack might well lie outside family and kin.

7.3 Adapting to life with diabetes

Florence was diagnosed as diabetic some 20 years ago. The hospital in Bafut established that she had diabetes and she was placed on drugs. But friends and family members informed Matthew (her husband) that Florence's illness could be cured by traditional medicine (see Matthew and Florence on figure 15). He subsequently invited many of the traditional healers suggested to him to his home to perform healing rituals whenever Florence was bed ridden. And when she could walk, Matthew took her to a traditional healer's home. After many attempts, Matthew brought her back and concentrated on getting her treatment at home. He separated his apartment from that of Florence, where she was sleeping with the grandchildren. Later, Florence went into a coma and was admitted to the Catholic Hospital Shishong at Nso, some 150 kilometres north of Bafut, where the family stayed for 3 months. On discharge of Florence from the hospital, Matthew was dismissed from his job of Treasurer. His wife's illness had plunged him into huge debts of over one million FCFA (about £1000). Florence was placed on insulin, and when this was finished, she was prescribed glibenclamide and metformin. Matthew resorted to always keeping sugar at home and taught his daughter and grandson to give Florence sugar, whenever they discovered that she was in a coma or started behaving unusually. Matthew could never stay away from home for long when he was not at work. They either went to the farm together or he made sure that the daughter or grandson was with her always. Florence was exempted from most house and farm work. Matthew, the other members of the family, her Church and other social groups, always turned up to help in the farm or give her food. When Matthew was hard up, he borrowed from friends to keep her supplied with drugs. His children, brothers and sisters working elsewhere also periodically assisted them with money or some products, which they thought might help cure Florence. Initially, Florence's food was prepared differently from that of the rest of the family, making sure that there was little salt and oil in it. Florence was prohibited from taking alcohol and sweet beverages. However, she preferred taking alcohol because she thought it did not contain sugar. Florence was always on drugs and always needed money to the extent that some of Matthew's friends advised him to send Florence back to the parents. But he refused.

(Extract from fieldnotes, Bafut, 11 July 2002)



Figures 15: Matthew and Florence

The case material, drawn from my fieldnotes, with which I start this section, is in some respects unusual, for Florence – and her family – had been coming to terms with the implications of her diabetes for very many years. But the extract suggests a number of points, which I shall pick up on below. First, diabetes is rarely simply an individual matter, to be handled by the patient alone. It is essentially a family matter, but also extends beyond the family to encompass the wider community and the church to some degree. Second, this particular household was one where every effort was made to adhere to the treatment doctors and other clinic staff prescribed. Third, trying to follow that prescribed course has been far from easy. Not only are drugs costly in

themselves but they are a drain on the slender resources of many households. In this case, as is shown, Florence's ill-health plays a major part in costing Matthew his job, thereby compounding their financial difficulties. Fourth, despite the attempts to comply with clinic advice, traditional healing is not rejected, but seen as an important supplementary source of knowledge, insight and therapy. And finally, advice on diet and alcohol consumption is not seen as straightforward and easy to follow. As another diabetes patient – a participant in a death celebration in Bafut – put it, 'We are told not to drink palmwine, but this palmwine is medicine to us. When we drink we eat *achu* soup to neutralise the palmwine'.

The case of Florence and Matthew is an example of how families had to face big challenges when one member was diagnosed as diabetic, notably concerning diet, alcohol and money. One dilemma revolves around the pros and cons of cooking separately to reflect different dietary constraints:

> ...When we want to cook food at home we cook her soup differently and ours differently so she does not join [mix] his soup with us. At times, we cook food in the same pot, remove his own then add oil and salt in ours...
> (Declaration of a family member in Biyem-Assi, 28 July 2001)

This was a difficult issue which cropped up repeatedly. A number of patients resisted the idea of dietary curbs, and therefore came into conflict with spouses or other family members who sought to impose clinic advice about diet. These patients resented the idea of having their lifestyle monitored by their own family; and even where that was not so apparent a number of patients clearly disliked the daily reminder of their own vulnerability alongside the daily enactment of the 'normality' of the rest of the household. The sense of grievance in such circumstances was easily duplicated on the other side, for those trying to prepare what they saw as appropriate and medically-

advised meals felt that they were showing their love and acceptance of the individual concerned and his/her dietary needs. Not to prepare such food would be an act of neglect. At some extra expense and considerable extra time their actions were done as a way to demonstrate that the family were bound together. To have that repudiated as intrusive and restrictive monitoring of individual behaviour was in itself a source of grumbling resentment.

But of course all this could work the other way around. For there were instances where individual diabetics were unhappy with family reluctance to provide the appropriate diet, typically on grounds that the extra cost was too great. The consequence could easily then be a feeling of a lack of care, and a resulting mutual resentment.

If these can prove difficult matters to deal with within the home, they can be even harder outside, in more public socialising or on festive communal occasions. While some individuals disliked being singled out and treated as an exception, others were unhappy if their particular needs were overlooked or disregarded. Ensuring that the diabetic individual remains healthy is usually seen as a shared family responsibility. But the ideal is not necessarily realised in practice, and there is often considerable tension between husband and wife and parents and children, particularly where one is felt to be undermining the efforts of the other.

Similar difficulties and misunderstandings surface around alcohol. If diet provokes argument, alcohol does so even more. Men commonly referred to the difficulties they could face among friends and peer group if they were not drinking alcohol. 'My

friends do not more want to go out with me because I drink Soda Water. They tell me to stay at home and be doing that.' For men, drinking beer is a means to show-off, look important amongst people and refuse to be dominated. Not to drink is somehow to reduce oneself. But Guinness is something of an anomaly here.

> ...You see that I don't drink much beer. When I come to this bar, I drink my Guinness and it makes me to feel strong. I have been told that it is good for diabetes patients because it is bitter...
>
> (Stephen, diabetes patient in Biyem-Assi, 22 January 2002).

Some diabetic patients (men especially) have convinced themselves that while they ought to keep off beer, it is perfectly safe to drink Guinness. Guinness tastes bitter; and in popular understanding its bitter taste places it in contrast to the sweetness they know they ought to avoid. Bitterness stands for good health, contrasted with sweetness signifying illness. What better to neutralise the excess sugar in the body than the bitterness of Guinness?

> In a conversation with Adeline she explained how she was trying to cope with the nutritional habits of her husband and family. She prepared either sour or bitter food for him. Though she opposed her husband's excessive alcoholic consumption, it did not hinder him from resorting to sour fermented palm wine and alcoholic beverages like Guinness. They owned a garden where they planted bitterleaves, paw paw, mangos, guavas, oranges and sour-sop trees grown not only for the fruits but to serve the husband. The bitter leaves are harvested and prepared as vegetable soup for most of the meals of the patient and the leaves of the fruit trees are harvested and prepared as herbal tea for the husband.
>
> (Extract from fieldnotes in Biyem-Assi, 4 October 2001)

People also understand that the excess consumption and presence of sugar in the body causes diabetes. In order to deal with this, one response in a number of households is to provide food that is thought to be sugar-free, but at the same time to encourage alcoholic beverages seen as particularly bitter. The emphasis on the destructive power of sugar opens the way for higher alcohol consumption either in its traditional or in its industrially brewed form. Thus the local palm wine is widely seen as 'safe', while in

addition the messages used by Guinness Cameroon to advertise its products have had the same effect, even to the extent of being read as a cure for diabetes and some of its complications. Thus diabetes patients drink Guinness as a medicine to 'cure' diabetes and as a 'cure' for sexual and erection dysfunction.

There is an important gender aspect to this discussion about diet and alcohol, which I must now consider, for it mattered a good deal whether the diabetic was a man or woman. While it would be a mistake to suggest a complete contrast, it was more typically men who as diabetics resisted the dietary changes their wives and children sought to introduce; and it was more typically women as diabetics who felt that their requests for the consideration of special dietary needs were disregarded with the claim that the money was not available to accommodate such needs. The good wife is the one who strives to meet the husband's dietary preferences. The kitchen is her space. But when her definition of what is good food for her husband conflicts with his notion of the same, the stage is set for difficulty. In parallel, the man's command over household financial resources tends to guarantee him – if he is diabetic – priority access to drugs, treatment and special food, if he intends to comply with clinic advice; but if the diabetic is a woman she often has a harder task in asserting an equivalent claim on household financial resources. Even where she does gain fulsome backing from her husband or family initially, the long-term nature of diabetes means that there are likely to be bigger uncertainties over sustaining such financial commitments in the case of female diabetics.

There are parallels in relation to alcohol consumption and changing behaviour. While resistance to curbing alcohol consumption was by no means only a matter for male

diabetics to confront in a cultural climate where women as well as men drink alcohol, nevertheless the greater resistance was usually among men (see figure 16), with the urging of restraint more typical of wives and daughters.

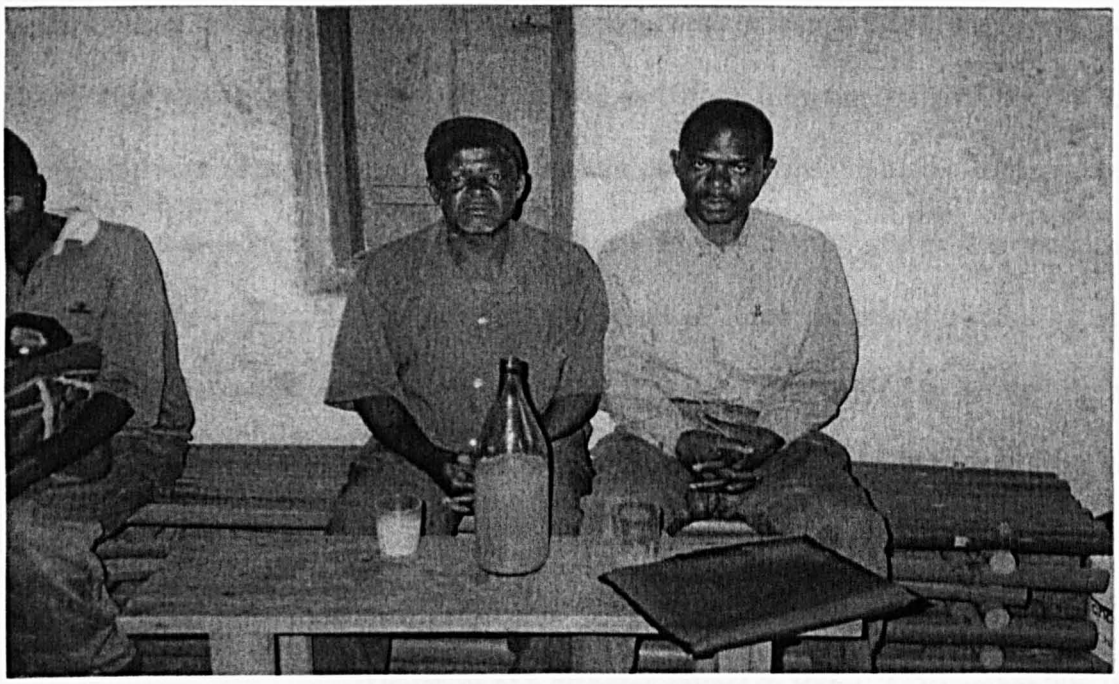


Figure 16: Ambition shares a litre of palmwine with me

Moreover, when a woman becomes diabetic, the shadow hanging over her is that her husband may eventually separate or divorce her. That can work the other way also, for wives leave diabetic husbands too. But the former is both more common and less stigmatised. The title of Goheen's (1996) book highlights that "men own the land and women own the crops" (also Kaberry 1952, Nkwi 1982). And acknowledging women's primary role in the domestic sphere in the language of the public sphere, people commonly refer to a married woman jokingly as 'Minister of the interior'. Both Goheen's title and the attribution just mentioned stress women's position and status while at the same time making it evident that such status is secondary to men's. Even so, she needs to remain healthy just to enjoy this status. The point I want to

make here is that when a married woman develops diabetes even this status can become compromised. Diabetes and its limiting complications can lead to a husband supplanting his wife's control in just those arenas where formerly she would have expected to have influence, as he takes up even what is reserved as a woman's right and privilege. While diabetic men might bemoan a certain loss of face if they were no longer able to join as freely in social drinking as before, they rarely found their own domestic power as controller of family finances put in jeopardy in a way comparable to the loss that women may experience. But having summarised this broader pattern of gendered inequality, I want to emphasise also that some spouses showed a lot of concern for each other, and supported each other tirelessly in seeking to get the other well. Moreover, children also play major roles in assisting one parent to manage the needs of the other, diabetic, one.

> ...Every month, we send money to our mother to make sure that she has all her medicines and eats properly...
> (Daughter of a diabetes patient in Bafut, 3 Devember 2002)

> ...My children are still young and help me to keep the house clean...
> (Jean-François, diabetes patient in Biyem-Assi, 5 November 2001)

This leads me to the generational aspect of diabetes care. Mature children, if employed and earning salaries and living at a distance, typically provided considerable financial assistance to support a diabetic parent. Younger children might assist their diabetes parent(s) in household and farm work. Children indeed were seen as the main pillars and symbols of strength in a person's diabetes management support network. Besides, they serve as a form of social security in an environment where there is virtually none, especially in health care. In Cameroonian society, people expect that a child should be responsible and should care for the parents when he/she 'becomes an adult', and this obligation is accentuated in the event of a chronic illness

like diabetes. While parents are regarded as custodians of a child's wellbeing because they deliver them, and perform several rituals to sustain their lives, the child, in turn, looks up to the parents for all his/her ritual and spiritual wellbeing. Parents are seen as intermediaries between their children and the ancestors, for parents are closer to the ancestors. But parents can also call on ancestral support if children are reluctant to pull their weight in the inter-generational bargain. As a last resort, if a child is unwilling to assist at a time of parental need, parents can call on ancestors to sanction them.

Such principles are not always of much use in sorting out practical difficulties in modern circumstances. Many children of diabetes patients work in towns, often far away, and despite the expectation that children are automatically the pillars of diabetes management, the reality may make such an expectation unrealistic. Out of such realities, relationships easily become strained, the child never doing quite enough to meet with approval as the dutiful son or daughter.

It is not only diet, alcohol and money which are common causes of intra-family and specifically gendered tension. Sex also is quite commonly an area of considerable difficulty between husbands and wives. Something of this comes across in the following extract from my Bafut fieldnotes

> Florence has been ill for 18 years, moving from one healing home to another. The friends of Matthew had requested that he should send Florence back to her parents because she was always ill and never getting well but he refused. The ties between Matthew and the wife remained strong but Matthew had some liberty to himself. Once in a while Matthew had sexual intercourse with his wife to illustrate that he was not being promiscuous, because of her ill health. Quite often, he tried elsewhere as that urge could not be fully satisfied at home.
>
> (Extract from fieldnotes in Bafut, 10 September 2002).

Arguably, sexual difficulties around diabetes were more evident in the city than in Bafut. In the city – and Biyem-Assi is no exception – marital instability is widely seen as greater than in rural areas. With looser social networks, and fewer of the traditional social controls of village life, marriages often start sooner and end more easily. Even though there are village, social, professional and church associations that can provide some social and initial financial support to people in Biyem-Assi, they play a relatively slight role in keeping families together. The social cohesion and consciousness that is so pronounced in Bafut seems to be less evident in Biyem-Assi. Diabetes can easily compound these general pressures of urban social mores, as possible complications of the disease arise and as libido declines. Some couples in Biyem-Assi separate[5] and others seek divorce in law courts. One male patient lamented:

> ...The fact that I have lost my manhood has made my wife to go out with 'small boys'. She has finally packed into a young man's house where she thinks that she can be fine with sex...
>
> (Diabetes patient in Biyem-Assi, 10 January 2002).

But more commonly it is female diabetes patients who find themselves pressured or left by their husbands. Here again, in the context of sex just as with the social and financial leverage I discussed above, when a woman becomes ill with a chronic and life-changing disease like diabetes, there can easily occur a shift in domestic power relations. If diabetes can seem disempowering for men, it can seem even more disempowering for women. The following declaration of a female patient is illustrative of several such stories.

> ...He is surprised that he does not and can not more have sex three times a week. I can stay for months and it will not bother me to have sex. He wants

[5] Separating means that the spouse leaves the family home for an extra-marital partner, abandoning the diabetic partner at home, with the rest of the family.

> more children but I tell him that it is not good for my health. But he is insisting. I do not know what I can do. It's a bore and a duty. It is no longer out of pleasure that I do it. My husband has been complaining that he will look for a second wife. I have said I cannot more have children. I am afraid that I can be operated upon...
>
> (Diabetes patient at Biyem-Assi – 21 December 2001).

This woman's husband ended up divorcing her for another woman, to whom he got married because sexual relations with his original wife had ceased.

With the business of adjusting to diabetes having such a major impact on relationships within the household, what was the role of the Church (or Churches)? In many respects Churches played a vital role in sustaining families of diabetes patients, in reconciling family members to the serious implications of the disease and the necessity for making the changes necessary to adjust, and in trying to reconcile couples when marriages threatened to break down. This was true in both Bafut and Biyem-Assi. The influence works simultaneously on two different levels. First, it is commonly the Churches that run the clinics, thereby making churches a primary channel for biomedical understandings of diabetes. In this sense, the Churches stand for a certain sort of modernity, in which the promotion of 'modern' medicine and the disapproval of 'traditional' healers on therapeutic and religious grounds go hand in hand. Second, the Churches work to support marriage ties and to encourage respect for marriage bonds. For reasons outlined above, this task often receives particular emphasis when a member of a Church is ill with diabetes. In Bafut, paying visits to the homes of patients and occasionally providing them some assistance in counselling, money and farm labour, are some of the activities that the Churches perform to alleviate the burden of suffering of diabetics and their families. But in Biyem-Assi the practical support offered by Churches is less apparent and more nominal. The

Churches there emphasise Biblical teachings, that marriage is intended to survive through not only the best but also the worst moments of life. Families are urged to accept severe illness just as they do life's pleasures. But in relatively few cases so far as I could tell did support extend beyond exhortation in church to practical measures that might sustain family relationships strained by managing diabetes.

Diabetes can also require considerable changes to the economic roles and daily routines of patients and their immediate family. Agricultural activity is a case in point. The quote below explains some of these changes in economic activities.

> ...When she is going to the hospital, I go with her. I help her in cooking the type of food she needs. I give her money for her medicines every time. Any manual work that she is supposed to do at certain times, I just do it for her... My friends, my brothers also help financially; and also buy her those fruits which are recommended for her. She is not strong enough and does her farm-work only with her daughter. A few other people do that, especially her children in Christ...
>
> (Husband of a diabetes patient in Bafut, 5 November 2002).

Though agriculture is the main source of income for people in Bafut, some diabetes patients reduce the amount of time that they spend working in farms. Instead, they take up roles that are less strenuous, as a means of reducing fatigue, thought to be associated with diabetes. Family members aid working in the fields. By contrast, some patients in Biyem-Assi, because of the need to physically exercise, have recently started doing agricultural work.

The case of Florence with which I started this section illustrates a long effort to adhere to the advice of clinic staff. Many patients need several years of experience of diabetes and treatment to be able to manage their diabetes similarly. But even those patients most willingly seeking to follow clinic advice can easily find that hard to do,

and can experience times when they wonder how worthwhile it is to comply with the treatment and behaviour expected. In talking about their condition, most diabetes patients and their families describe it as an ongoing struggle to manage – whether they are seeking a 'cure' or not. Even in households which accept that diabetes has to be managed and cannot be cured, the lure of a possible cure cannot entirely be ignored. Part of the common currency of popular discussion about diabetes, whether in Bafut or Biyem-Assi, is to question why the clinics, with all their sophisticated technology, can only control diabetes, when a cure is potentially available in the traditional system of medicine. This is one aspect of a public cultural code in which 'curing' is tacitly the goal of all treatment. To be cured denotes power and agency, while treatment which only 'controls' signals moral chaos, and calls into doubt the scientific efficacy of modern clinical medicine. The following two extracts reflects something of this outlook.

> Tailor. Frankly speaking, as soon as you will not know what is happening to you, you will go anywhere to grasp anything to obtain a cure. Now that you know that you are diabetic the only thing you can do is to control.
> Sammy. Yes. That is true. One turns round like this because there is no way. You want where you can be cured, because the clinics are unable to offer one.
> Pastor. What I have understood with this disease is that the cure starts with your diet.
>
> (Extract of FGD with diabetes patients in Bafut, 21 January 2003).

> ... One patient proposed some traditional medicines in her house. He told me that this medicine cures diabetes. I went and took it and I am taking it now. I do not yet know whether it has cured my diabetes because still I have to go to the hospital for a test...
>
> (Prosper, a diabetes patient in Biyem-Assi, 6 December 2001)

Furthermore, the more patients or their families question clinic guidelines, the more likely they were to seek alternative treatment from some kind of traditional healer. When people with diabetes speak of cure, they simultaneously combine two discourses. First, they allude to the language of biomedicine used by clinicians, and refer to the presence or absence of bodily symptoms. But second, they also evoke

metaphors about the disorder of illness experience and about the diabetes patients' desire to assert a positive identity and agency in the management of their disease. The following remark hints at this:

> ...Since I always eat my *Tchah-Tchah*[6] when our choir goes on visits, everyone now wants to eat *Tchah-Tchah* like me...
>
> (Peter, diabetes patient in Bafut, 15 December 2002).

The frequent reference to cure and its multiple meanings form a central part of the moral discourse surrounding diabetes in Cameroon. In this, it is all too easy to inadvertently undermine the agency of patients already coping with a demanding discipline and a potentially disabling or life-threatening disease.

One of the most urgent aspects of diabetes concerns the complications which may ensue, and I now touch on the ways in which those I studied handled times of complication, which are by definition particularly stressful moments in the course of living with a chronic illness. These may easily be times of distress, when the pressure of events encourages some people to turn anew to traditional 'solutions', rather than relying solely on what may well be the more expensive option of biomedicine. My evidence concerning complications suggests that people generally consider complications of diabetes to be completely different illnesses, having nothing to do with diabetes; or that diabetes can only be effectively handled by traditional medicines by virtue of these complications. The understanding of these complications points to the fact that some people tend to exteriorise and manage diabetes in ways popularly fostered in local health beliefs.

[6] *Tchah-Tchah* is soup prepared with cocoyam leaves, prepared without oil but with salt. Cocoyam is a tuber plant whose leaves serve as vegetables and the tubers pounded into a paste called *Achu*.

One complication which male patients found most troublesome concerned sexual or erectile dysfunction. It was common to attribute its occurrence to witchcraft, and thereby to prefer to treat it as an outcome of conflict rather than a diabetes complication. Even those men trusting clinic biomedicine could be persuaded in this context to turn to traditional medicine. I thus come back to notions of 'compliance' and 'adherence', and ask in the next section what the idea of 'compliance' means from the perspective of patients and their families.

7.4 What does 'compliance' mean? Dealing with competing regimes of treatment

> ...As a matter of fact, going to a traditional clinic is not actually the problem. But knowing some grass that you can cook, make your tea – that reduces the concentration of sugar in your blood. Instead of going to buy this normal refined tea, coffee, you just get some leaves behind your house and boil them, drink them even without sugar every morning. It reduces the sugar in your blood. Instead of going to a herbalist you do it yourself. When you go to a herbalist, the tendency is to throw some *ngambe* [divination] and say, "Oh! Your uncle, that man has killed you, he wants goats". That is why I hate them. There are some leaves in the grasses. These leaves can sting and bruise you. In Bafut, we call them *asongha-nyi* [fern]. You cut the grass, come to the house and either boil or dry it. When you dry, squeeze it in the tea and you drink. You use any sugar with it. Your blood sugar will go right down. Frankly speaking, some healers only call you to cut this *nga-aa-nou* and a*songha-nyi* and mix and give you. All leaves add insulin on you. Whether they are guava, mango leaves, they add insulin in your body. So, if you can heal on leaves, why go there...
>
> (Peter, diabetes patient in Bafut – 10 January 2003).

> ...As soon as you will not know what is happening to you, you will go anywhere to grasp anything. That is one. Two, now that you know that you are diabetic, the only thing you can do is to control. You cannot cure diabetes. If the insulin in the clinic is effective, I will not be turning from the left to the right... One turns round like this because there is no way. You want where you can be cured...
>
> (Ambe, diabetes patient in Bafut – 10 January 2003).

The two quotes above are extracts from a conversation with some diabetes patients in Bafut during social drinking. Both the men quoted have had diabetes for some time, and count as 'experienced' diabetes patients, an important distinction because the passage of time as a diabetic is also necessarily a phase of learning how to 'manage' the disease. In these extracts, there are several interesting points to note: the use of the word diabetes, and an understanding that diabetes cannot be cured. These are coupled with recognition that people desire to believe that 'you can be cured' (second extract); and a demystifying of the treatment offered by some traditional healers, suggesting that a person can just as easily treat himself (first extract). Such statements will arguably bring some qualified reassurance to the clinics, for they convey an acceptance of at least some of the lessons the clinics seek to put across. Yet, in this last section of the chapter, I reflect on the gap that is apparent between clinic expectations of patient behaviour and the thinking and practice of patients themselves, and their families. Around the partly chronological series of aetiology and diagnosis, treatment and prognosis, there have emerged major contrasts between the world of the clinic and the world of patients and their families. It is this divergence that heightens the clinic rhetoric of 'non-compliance', which we noted in the last chapter, and which leads patients to be cast by clinics as deviant, to a greater or lesser extent.

However, from the perspective of patients and their families, there are other pressures to take into account and in a sense to conform with, the major one being the belief that illness is a form of misfortune. Biomedical explanations can readily be fitted into this frame of thinking up to a point. But biomedicine does not provide a sufficient explanatory framework for most Cameroonians, whether in rural areas like Bafut or in the city. Ultimately, ill-health is seen as having social causes, and 'complying' for

most patients, if it has any meaning at all, means recognising exactly that social dimension to causation, where resolution is likely in the end to be found through the performance of rituals. Whether the road to ascertaining which rituals need performing runs via a traditional healer or not, only the restoration of compromised social relationships will create the possibility of dealing with diabetes properly and appropriately, which is to say for many attaining a 'cure'.

'Compliance', of course, is a biomedical term underpinned by certain biomedical assumptions and values, which makes sense only to the clinic staff. The other actors in the care process are largely unfamiliar with it, and rarely if ever employ it themselves. The accusation of being 'non-compliant' can easily sound senseless to patients and their families, as they take it for granted that the causes of diabetes have a wider scope than clinic staff understand. Therefore, in popular understanding, diabetes warrants treatment seen as potentially commensurate with its 'causes', broadly assumed. Patients can easily think that their problems are only partially understood by the clinic staff, so make recourse to traditional medicine to complete what the clinic cannot assist with, thus they hope and believe completing the healing cycle. They adopt other medical treatments that they perceive can work better, and combine these with that of the clinic, for what they believe will be more effective results. From the clinic point of view, of course, such a rationale is nonsensical, and the patient is simply failing to comply as advised, and notably failing first by turning to traditional treatments, and second by ignoring the pre-eminent need to control blood sugar.

Only slowly are Cameroonians coming to terms with the fact that diabetes is not a curable disease. The ultimate aim of virtually all diabetes patients at the point of

diagnosis – and indeed afterwards – in Cameroon is still to be cured, so that when one talks of treatment it is equated with curing and not management. Faced with the fact that cures do not happen, and evidence of the chronic nature of the condition, there is a tendency to explain such uncomfortable truths by arguing that there were delays in starting treatment, or that something is holding back the cure – an argument that can easily lead straight to traditional healers. Some patients even suggest that perhaps their mistake is to be combining too many treatments in an effort to find the cure.

So scepticism about the efficacy of biomedicine and what clinics can offer runs deep, as the following remarks convey:

> ...If scientist can discover a bark of tree, medicine to cure AIDS at the Korup National Park, what about diabetes? I am convinced that you have one there or in another forest that can cure diabetes...
>
> (Chrisan, Diabetes patient in Yaounde, 13 October 2001).

> ...You go to the hospital, come back and after a few days you are fine. It comes back again. Just like that. But the traditional healer will tell you the type of diabetes that can be treated in the hospital. When you disobey and go to the hospital you die, because they will just waste your time in the hospital...
>
> (Family member of a diabetes patient in Bafut, 17 January 2003).

Even many of the educated elite, who may on one level understand that diabetes cannot be cured, still think that a cure may be obtained through intensive research within the wide range of medicinal plants found within the Cameroonian flora. People do not readily accept that other conditions may have a cure but diabetes is incurable and without a cure in prospect.

However, there is more than scepticism about the efficacy of biomedicine at issue here. Financial considerations are also a major deterrent to following the clinic path. The absence of health insurance policies has made it difficult for patients to obtain

quality diabetes care, and many patients simply lack the money – or consider themselves as lacking the money – to go through with the full advice and treatment clinics propose. The very business of accessing my samples of patients through clinics initially might be said to skew this study towards those who at least had the funds to seek clinic care. Some patients and families dip in and out of clinic treatment regimes for precisely this reason. Even the prominent Church-run clinics charge sums which can bear very heavily on poor families, whatever the extent to which their costs are subsidised. It is in this context that traditional healers assume importance, for invariably their procedures are seen as much less costly. The promise of being cured, and for far less cost, is a seductive one for those yet to be persuaded by the credibility of the clinics. Healing based on local herbs, which may be abundantly available in the bushes in rural Bafut or cheap to buy from markets in Yaounde, commands enormous support. At times, moreover, people may conclude also that the medicines prescribed at such a cost in the clinics are fabricated from these same readily available plants, reinforcing the state of mind that there are more viable and less ruinous ways to treat diabetes than by following every stipulation of clinic regimes.

In addition to the factors considered so far, the impact of AIDS on certain wider health beliefs and practices should not be under-estimated.

> ...I used to weigh 90kg, when I was 25 to 35 years but I have lost more than 10kg now. When people see me now they say maybe I am suffering from AIDS. I have cut down my weight and it is affecting me. I have to gain a bit to remove that stigma and show them I am well...
>
> (Christophe, diabetes patient in Biyem-Assi, 7 November 2001).

The emergence of diabetes as a significant public health problem across sub-Saharan Africa has coincided with HIV/AIDS. Both are chronic conditions, and neither can be cured. But for the diabetic and his/her family, a major consideration is precisely not to

be mistaken for an AIDS sufferer. Too much stigma attaches to AIDS to make such confusion remotely a tolerable possibility. And in this possibility of confusion, weight is the key, as the comment above shows. Sudden weight loss in sub-Saharan Africa is now readily associated with having AIDS. Yet one of the main ways of managing diabetes is through weight control, which usually means weight loss. Such advice to lose weight is something which most diabetes patients find instinctively difficult to follow, because of the fear of being thought of having AIDS. In fact, the question of weight loss, although now overwhelmingly associated with popular attitudes to AIDS, actually goes beyond AIDS. For what is now being considered 'overweight' has in the past been taken as a sign of good health, wealth and vitality. While diabetes patients will often now accept that weight loss can improve their quality of life and health, the very idea flies in the face of some deeply held assumptions about the ideal body.

In many respects, the patients I knew best, both in Bafut and Biyem-Assi, certainly saw themselves as seeking to follow clinic advice. However, the belief that they were doing their best to follow these guidelines rested on the assumption that supplementing visits to the doctor and clinic with visits to a traditional healer was a sensible course of action, and very far from being deliberate or flagrant disregard of the clinic. Patients and their families, on the one hand, and clinic personnel, on the other, thus, construe the same actions quite differently. Moreover, what senior clinic staff express in terms of compliance is commonly construed by patients in terms of restrictions and prohibitions, a long list of do's, don'ts, and costs. Traditional medicine escapes this image problem, working as it does with the grain of popular knowledge rather than in challenge to it. Moreover, if a traditional healer (typically in this context a diviner) identifies an ancestral cause, many patients and their families

will consider that they simply have no choice in the matter: they have to act to address whatever shortcomings the divination identifies

Although compliance and adherence have been extensively researched, it has been argued that the outcome of much of this work provides little consistent information other than the fact that people do not always follow the doctors' orders (Morris and Shultz 1992, Kyngäs 2000, Bissell et al, 2004, Broom and Whittaker 2004). The main function of such terms (according to some) is ideological: to provide a framework for doctors to express their ideas about how patients ought to behave (Trostle 1998, Thorne 2000, Britten 2001, Thorne et al 2002). In recent years, the idea of *lay expertise* has been given some prominence, whereby patients gradually come to 'accept' their diagnosis, and, gain mastery in coping with it (Price 1993, Mitchell 1998, Broom 2001, Bissell et al 2004). It has been suggested that the psychological and physical stresses of diabetes call for specific adaptive and coping strategies, and that many patients so diagnosed, experience difficulty in adapting to the regimen (Miller 1983, Kelleher 1988, Bissell et al 2004, Broom and Woodsward 2004). The social context of patients' lives may have a profound impact on decisions to comply with the treatment regimen. For example some authors (Drummond and Mason 1990, Bissell et al 2004, Broom and Woodwards 2004) have suggested that the goals of treatment from the medical perspective are largely concerned with maintaining blood glucose levels within an acceptable band. However, people with diabetes often identify a much broader set of constraints which influence treatment, including work, housing, finance, family, and emotional factors. For example, dietary and medical non-compliance does not occur as a result of an idea or whim on the part of the patient (though of course it may) but, rather systematically, as part of competition between

constraining factors. Most of this literature concerns the richer countries of the world. Even so, there are parallels here with Cameroonian circumstances, in the sense that in Cameroon, as elsewhere, the language of compliance and adherence is the language of the clinic. It is part of the modern repertoire of clinical surveillance, whether applied to Cameroon or the UK. Do Cameroonian patients absorb this language, and see their own behaviour and actions in terms of degrees of compliance? As the ethnography presented in this chapter shows, only to a rather limited extent.

7.5 Conclusion

If one observation stands out in this chapter, it must be the deep-seated public belief that diabetes, like all other diseases, is potentially curable. It does not matter whether we are considering Bafut or Yaounde; for this assumption is just as prevalent in each place. A public health message that promises you a lifetime of 'managing' this disease, learning to adjust and live with the limitations it imposes on you, requiring that you follow stringent 'rules' of behaviour, if you are to avoid an acute crisis and likely death, is not an appealing one. Many, even among educated sections of the population, thus find themselves seduced into thinking that maybe there is a cure, and that the search for a cure is worthwhile. But how much is changing, and to what extent will the next generation of diabetes patients deal with these choices and pressures differently? How much will the growing appeal of science transform those attitudes and frames of mind that I have been discussing here? Are there clues in this regard if we contrast Bafut and Biyem-Assi? That is hard to say at this point. What I can say is that Bafut and Biyem-Assi resemble each other more than they diverge. There is not to any marked extent, I would emphasise, a rural analysis to present and a separate

urban one. It may be that Bafut's close proximity to the large city of Bamenda has been a factor here. But perhaps the primary point is how resilient so-called 'traditional' ideas prove to be in relation to critical matters of health in the urban context. When diabetes is diagnosed, rural and urban people alike strive to make sense of it combining old and familiar taken-for-granted ideas as much as new and unfamiliar practices.

The differences in the types of knowledge upon which health professionals, diabetes patients and their families base their assessments can lead to disagreement and mutual resentment in which physicians accuse diabetics of not grasping the severity and implications of their condition, and its life-threatening complications. Generally the patients themselves consider such charges unjustified. This, in essence, is the clash around compliance which has figured so prominently in these last two chapters. But here the task has been to show how diabetics and their families make sense of their circumstances. This means showing why what clinics regard as 'non-compliance' is seen very differently from the patients' side. I have tried to avoid homogenising the picture I have painted, for the ethnography shows how different individuals seek different paths of treatment for themselves and family members, some being much more convinced than others by the efficacy of biomedicine.

Chapter VIII

The perspective of traditional healers

8.1 Introduction

> ...For some people, when their manpower [erection] is weak, it is because somebody put him medicine on the road and he stepped on it. Another one is that put in an Indian bamboo. When it is put in an Indian bamboo they place it on the road, then when you are passing and step on it, you will carry it [you will be infected]. When you step on it, it will break like this, 'juaah', then it will mean that you have carried it. They even put *nighoni-shugar* [diabetes] into somebody's skin [body]. They can come in witchcraft and visit you in the night, then soon you start to have problems. When you are sleeping in the night, you see only bad things and have bad visions, you can have *Shugar* [diabetes]. You are sleeping in the night and a woman comes and has sex with you. When you have the sex you become very weak. You will not more have manpower [Erection]. When you wake up the next day your skin will be broken [weak]. That is witchcraft. They have come and given you diabetes through witch... *Shugar* can be around and when a problem occurs in a family, the diabetes will find its way in. It can also happen when a family installs a wrong successor. The ancestors immediately make people in the family to be sick with *Shugar*. But, if the family decides to install the right successor afterwards, the diabetes will finish. That one is very normal... There are some people that, when you bring down [reduce] the *Shugar* in their body they instead go and provoke a different illness in the skin. That is; they have made you weak! When you pass somewhere, where someone has kept his medicine in the bush and you spit or steal, *Shugar* will infect you... This sick disturbs, so the only thing is to send the sick person to the hospital, to do a check-up... When that happens, I advise them that they should do a proper succession ceremony for their father's successor. I will tell them to go and do *Country Fashion* [traditional rites] and return to me for treatment. If that is not done, the *Shugar* will continue to be there, no matter what you do. And enough time will be needed to treat [cure] him. At that time, I wash you and give you some medicines. If you have been poisoned with it, I will give you medicine to eat, to wash out the sick, and after that you will be well. But I make sure that you don't eat above the quantity needed because it can make you to be sick again...
>
> (Alhadji – Traditional healer at Bafut - 10 March 2003)

I conclude the presentation of ethnographic data by focusing in the part played by traditional healers in the diagnosis and treatment of diabetes. As I hope to show, the actions of patients and their families, discussed in the last chapter, only fully make sense in the light of the competing attractions of the clinic or hospital, on the one hand, and the traditional healer (who comes in numerous forms), on the other. This

chapter therefore completes the picture by taking seriously the contribution of traditional healers, their claims, and their particular perspectives, on diabetes.

The quote above comes from a 40-year-old man in Bafut, and touches on several themes, which will be developed in this chapter. I would highlight the following: the causal role attributed either to witchcraft or to succession problems in which the ancestors make their displeasure felt; the significance of sexual problems or sexual events as signs and symptoms in detecting diabetes; the recognition of the role of blood glucose in diagnosis, and the way in which traditional healers refer clients to clinics because they see clinical services as working in conjunction with their own practices; the assumption that diabetes can be cured; and the reference to dietary moderation. In this respect the remarks by Alhadji above, provide a neat overview of a series of beliefs and assumptions recurring in many conversations with other healers.

Several of these themes have cropped up in the last chapter from the patient's perspective. What is new, and worth highlighting, is how traditional healers articulate a role for themselves, which they see as complementary to the clinic rather than as in opposition. Indeed, as I go on to show, this is sometimes more than a vague expression of compatibility. For on occasions, and out of sight of those in senior positions who would have no truck with such behaviour, patients and their families may conspire with staff to bring traditional healers into a hospital, to boost the patient's treatment.

This chapter starts with a discussion of the different categories of traditional healers I encountered (8.2). As well as documenting the terms by which these men (and all were men) describe themselves or are described by others, I also comment on their appearance. I then move on to discuss beliefs surrounding the aetiology of diabetes, and appropriate or effective forms of response and treatment (8.3). The next section looks more closely at healing practices, and what is it that makes healers' performance convincing and reassuring to patients: what is it, in other words, that keeps patients coming to consult; and why traditional healers retain people's trust in a way that seems nonsensical to many working in biomedicine (8.4). This leads on to consideration of the relationship between traditional healers and clinic staff. In principle, there is no relationship – certainly if senior clinic staff are questioned. In practice, my ethnography suggests that matters are not quite so clearcut (8.5). I end by discussing the importance of traditional authority in Bafut for an understanding of how patients and their families behave (8.6). This section relates solely to Bafut, but in it, I argue that we cannot understand local attitudes to diabetes without some brief reference to the authority of the Fon and some of the supporting political-ritual structures of the kingdom. For the reproduction of popular knowledge, about diabetes (as with all types of healing) is to some degree shaped by traditional authority.

8.2 Who are the 'traditional healers'?

The purpose of this section is to present the main types of traditional healers I encountered, and to discuss the local idioms through which these healers are classified. The term 'traditional healer', as discussed earlier, is one of convenience. It

is not a term in local use among English speakers, in either Bafut or Yaounde. On the other hand, its French equivalent, *geurisseur traditionnelle*, is part of common currency in francophone circles, along with the term *tradi-practicien*, including in self-promotion such as the advertising of services on sign-boards. More typical in local English idiom and in Pidgin as a generic term is 'native doctor'. These terms embrace a host of practitioners whose claims to healing skills may rest on the use of plants, animal or inorganic products like earth and stone particles, or divination. Despite their differences these generic terms are used to denote the contrast with 'western' medicine. In Bafut, there is a term, *Mou-Ngang*, which does have a general meaning, and thus comes close to the all-encompassing connotations of 'native doctor' or 'traditional healer'. *Mou-* has the meaning of a man, but also a child, while *Ngang* denotes medicine. The term thus conveys the meaning of both a 'child of medicine' or a 'man of medicine', tying in with another term sometimes heard, 'medicine man' (used for example by Gufler 2003).

In Bafut and much of the Grassfield, and indeed to some extent among English-speakers in Biyem-Assi, those who are diviners are called *Ngambemen* in Pidgin. In Biyem-Assi, the French *voyant*, or seer, is widely used. *Ngambemen* are believed to possess four eyes, enabling them to see beyond the 'natural' (Zeitlyn 1987, Pool 1994, Feldman-Salvelsberg 2002, Goheen 1996, Gufler 2003). According to Pool (1994), they are able to 'see' what others cannot see, detecting the ultimate or hidden causes of events and occurrences which trouble those who come to consult them, including the nefarious activities of witches. Gufler (2003) for his part describes these as 'medicine men', who have been given psychic powers by god while still in their

mother's womb. They too put their psychic powers to constructive use in combating the malevolent activities of witches.

In Biyem-Assi, a higher proportion of traditional healers see themselves as specialising in herbal treatments rather than divining. For example, those practising herbal medicine often say, 'I am a doctor of natural medicine, so I use only herbs in healing my patients'. This tends to be emphasised as part of a claim to be taken seriously as having specialist knowledge of plants, rather than relying on 'superstition', as diviners are tacitly assumed to be doing. Certainly there seemed to be a more educated clientele in the city who are not inclined to go to those claiming mystical or psychic power but who nevertheless are ready to go to practitioners using traditional herbalist knowledge. The importance of firmly distinguishing one's diagnostic practice as based on herbal therapy rather than divinatory power was all the more critical, in fact, because diviners from certain ethnic groups in the city (the Ewondo, Maka and Bassa for example) are widely assumed also to be witches themselves (cf. also on this theme Boyer 1986, Rowland and Warnier 1988). Your reputation as a healer is because you are perceived as skilfully using herbs and your *Evur* (witchcraft) to achieve extraordinary results, as one traditional healer affirmed: 'to understand some of these things about diabetes, you also need to be a witch'. Stressing herbal knowledge allows a practitioner to mark himself off from any such possible association or suspicion, and simultaneously to assert a claim as a serious medical practitioner, in some ways on a par with 'western medicine'.

There are certainly herbalists in Bafut also, even if diviners there do not come under the same suspicion of practising witchcraft themselves, as their equivalents in

Yaounde sometimes do. (Only one traditional healer in Bafut told me that all 'true' healers had to be witches themselves, in order to understand what they have to combat; but this does not seem a widely shared viewpoint so far as I could ascertain.) One of my main informants, Bob, describes himself nowadays as a herbalist. 'I am a herbalist, so if you have diabetes I will give you a grass that you will eat and that will enable you to pass out the diabetes in urine.' But it may have been significant that he emphasised his herbalist identity, for his account of his own initiation into healing work stressed how he had been led and taught through encounters in the forest with gods and spirits. It was through these 'divine' encounters that the plants or herbs that he used were 'revealed' to Bob; and he voiced his continuing allegiance to these spiritual guides.

In this way, Bob is an example of both a diviner and a herbalist, and it may be for reasons similar to those expressed in Yaounde that he preferred to stress to me that he saw himself as a herbalist, asserting a claim to credibility and respectability in the process. (On the other hand, knowing of my association with the hospital and diabetes clinic, it is possible that he felt it necessary to assert an identity that he may have felt would give him more credibility in my eyes.) Through his vocal style of self-presentation, characteristic of many traditional healers, he might have also wanted to distinguish himself from many of his peers. His explanations were certainly also in response to the needs of diabetes patients who had found solace in some herbs as the cure for diabetes. Emphasising the herbal knowledge that may accompany divining skill can also arguably be seen as a convergence with modern medicine's stress on the importance of vegetables in the dietary care for diabetes. Hence the emergence of a self-proclaimed branch of traditional medicine called herbalist.

This does not exhaust the types of traditional healers. In Biyem-Assi, there are also Christian and Moslem faith healers (*Marabouts*) who draw on Christian and Islamic beliefs in their healing procedures. For example, a diabetes patient who felt himself bewitched, because his fasting blood sugar remained high in spite of all efforts to reduce it, visits *Père* Souffo[1] with a container of water to enable him bless it for cure.

> ... When I consult a patient I pray with him or her. If it turns out that the patient has a problem with the family in the village, I ask him/her to go and settle it and reconcile. When the patient returns, I pray and make miracles and he/she gets well...
>
> (*Père* Souffo, Christian faith healer in Yaounde, 22 March 2002).

Many people are not quite sure whether to see *Père* Souffo as a traditional healer or a Christian Priest. In a sense, he is both combining the Catholic liturgy with open-air divination at the same time, and in the process demonstrating his divining and healing powers.

In Biyem-Assi, most traditional healers live in rented homes, in poorer quarters of the city, where housing is cheaper. Few have anything but small working spaces; and most herbalists depend on nearby markets to obtain their medicines. A number use signboards to advertise their presence and promote their business. Signboards may carry messages advertising the range of diseases that a traditional healer is capable of treating and the associated services that he can offer. But the signs on the signboard also communicate subtle or not so subtle messages in the internal politics of traditional healing. Some carry horrifying pictures, which the practitioners obviously judge to be the only effective way to make an impact. On the other hand, traditional

[1] Père Souffo is a healer living in the Carrière quarters of Yaounde city, purporting to cure diseases and cast demons using Christian spiritual powers.

healers who belong to a wider association look down on this kind of self-promotion. The very fact of belonging to a traditional healers' association is enough of an indication, as they see it, that you are worthy of trust, and a sober signboard or even the absence of such advertising is seen as a mark of respectability and competence. Garish or outlandish signboards are thus often seen as advertising thieves or quacks, unreliable figures, who might move off at any time.

In their appearance, many traditional healers seek to mark themselves out. Whether they wear suits or not, they commonly adopt some kind of traditional attire or regalia: say a particular walking stick, or a traditional Bamenda cap, or a Hausa-style cap (see figure 17 and figure 18).

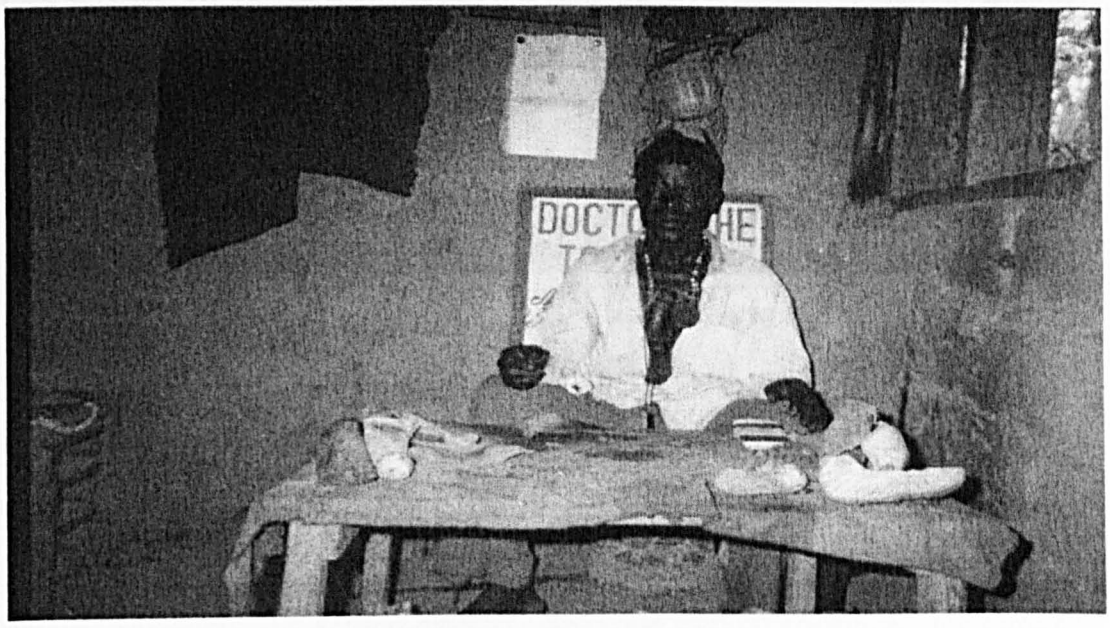


Figure 17: Dr Tumasang (Bafut) performing a divination

As I have already implied, in Biyem-Assi, traditional healers come from numerous different ethnic groups. But a majority are from the Grassfield, which has something of a reputation for producing credible healers. Their reputation stems from the fact that they have easily adapted their practices to suit the needs of urban residents -

descendants of numerous ethnic groups. Moreover, by adopting some of the medical practices of other ethnic groups, blending them with their 'own', these traditional healers have widened their clientele and extended their repute. That has earned them a lot of confidence from patients and their families, especially as they try to dissociate themselves from witchcraft associations.

Figure 18: Dr Ayissi in his traditional clinic at Biyem-Assi

In Bafut, traditional healers live in their compounds, fenced with mats, bamboos and bushes. Inside each compound, those using plants are likely to have a number of the most important medicinal plants growing, to provide a ready supply. In some cases, the middle of the compound has a hedge of medicinal plants expressly to protect the compound from any evil which might be directed against the healer himself or his family by those whose own ill-intentioned activities had been combated (see figure 18). Inside the homes of the healers are decorations and objects piled here and there.

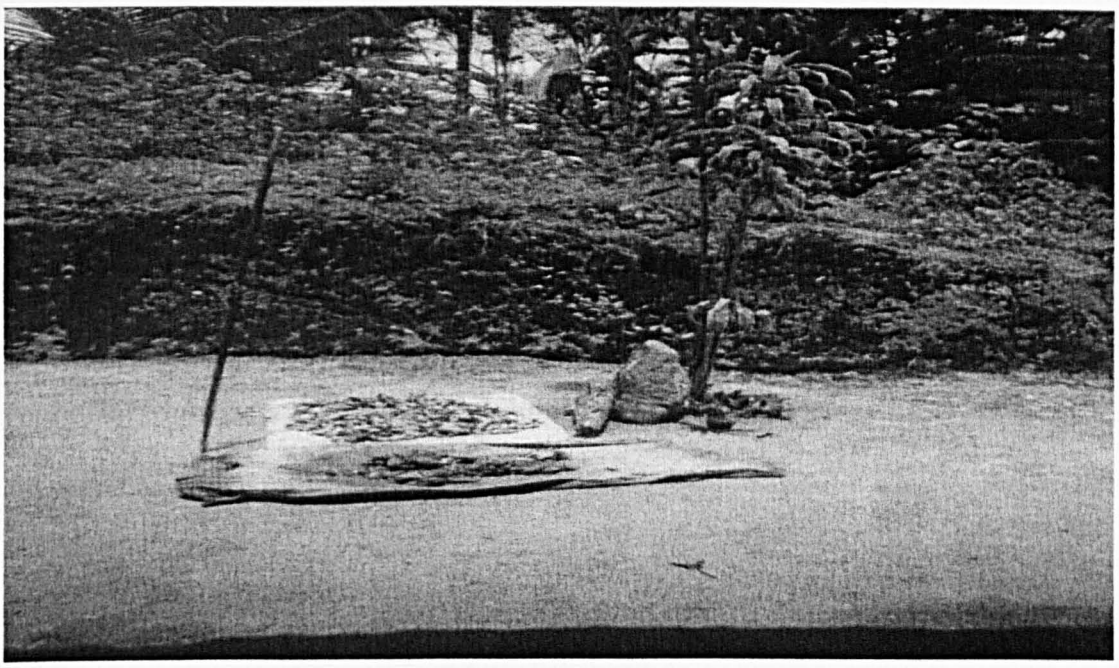


Figure 19: Typical compound of a traditional healer in Bafut

Individual healers use various phrases to describe to me their working environments: 'medicine house', 'traditional healing home', 'temple'. Some have waiting and consultation rooms. The colours white, black and red dominate. Red, the colour of blood, signifying the human blood that is infected by diabetes but also the animal blood, of chickens and goats, sacrificed in rituals as offerings to seek the cleansing that will restore the patient to full health. Black is the colour associated with the darkness in which witchcraft is thought to flourish. And white is the colour associated with success, the triumph over adversity, misfortune and ill-health.

Traditional healers in Bafut had no single style of dress. But it is noteworthy that it was their general dirtiness that clinic staff (and others) often mentioned. I interpret this suggestion of a 'dirty' appearance differently from those who take a dismissive line, and tend to argue that dirtiness is the enemy of the cleanliness necessary for all

medical practice. I suggest instead that this 'dirtiness' must be understood as deriving from a conscious rejection of certain standards of the everyday or the conventional. For those whose divinatory power came from outside the confines of everyday sight and knowledge, their appearance marked them out as appropriately 'betwixt and between' figures, in Turner's sense. Their appearance communicates that they are not to be judged by 'normal' criteria, and I also learned of a suggestion that the challenges or ordeals that had accompanied their initiation are reflected in continuing to adopt the appearance of that induction into their new status.

8.3 How traditional healers explain diabetes

My focus in this section is on the ways in which traditional healers talk about diabetes: its causes, its consequences and prognosis, and the kinds of treatment that are effective (See the opening quote of this Chapter). Traditional healers, broadly speaking, share most of the views about the underlying causes of diabetes, which I have already presented in the last chapter. They are, after all, members of the same community, heirs to the same cultural values or currents of change. But at the same time, they also articulated a more elaborate or developed rationale for the possible causes of diabetes, its nature as a disease entity, and its potential treatment. It is difficult to keep questions of treatment entirely separate from discussion of causes, for the two were so closely interwoven.

Basically, I consider three main approaches to diagnosing the causes of diabetes in this section. The first identifies diabetes as the consequence of witchcraft. Tackling it

means identifying and neutralising the source of the witchcraft. The second attributes diabetes to the sphere of kinship and damaged social relations – often quite unwitting and unrecognised – among kin. Succession is the crux here, and relations between the living and ancestors the focus of restorative action. The third focuses attention on individual eating and drinking habits – lifestyle in the idiom of western public health, though that concept does not mean a great deal to the majority of people in Cameroon. On the face of it, this approach to causation brings us close to the language of biomedicine and the clinic. But it is not so straightforward, for this is rarely seen as an ultimate explanation. It may explain factors precipitating diabetes, but it does not address the underlying causes.

Traditional healers are often brought in to perform their own 'diagnosis' after a person has first been given the diagnosis of diabetes at a clinic or hospital. Diagnosis at the hospital reveals to the patient that the signs and symptoms he or she is suffering from is diabetes. But what it fails to explain is where the diabetes has come from and why it has affected that person and not another. For that reason people turn elsewhere to seek the 'ultimate' diagnosis from traditional healers, because it is widely believed that all illnesses have an underlying cause independent of the affected individual. People live with these latent 'causes', but need the skills of a traditional healer to put their finger on the hitherto unrecognised source of the problems which ultimately are responsible for the emergence of the diabetes in a patient. In some cases, traditional healers' knowledge of some of the signs and symptoms help them to diagnose that a person is diabetic. When he divines/ diagnoses, he often encourages the person he is treating to attend a modern clinic for confirmation or tests. A traditional healer who refers a

patient to a health unit for the confirmation of diagnosis does this only when he is very sure that his diagnosis would not fail.

Many patients press their healers for divination, as the following remark suggests:

> ...At times patients come for treatment and pressure me to conduct divination. Some will insist, without me telling them, that someone has put diabetes in them. But when you refuse he goes away...
>
> (Dr Tita, Traditional healer in Biyem-Assi, 16 November 2001).

But what makes a traditional healer confidently explain after divination that a patient is diabetic? When a patient explains symptoms, without being aware that these are indicators of diabetes, many healers can straightaway diagnose diabetes – but, and this is the crucial difference from the clinic, not as a straightforward illness, and instead as the outcome of a conflict. Performing a diagnostic ritual is not limited to revealing diabetes, but also the agency responsible for causing diabetes. The same diagnostic procedures described in Chapter VII are used by traditional healers, and reflect many common diagnostic practices in both Bafut and Biyem-Assi. In Biyem-Assi, some traditional healers, being aware of the fact that they may not interpret and predict events related to these signs and symptoms with exactitude, tend to explain the diagnosis of diabetes from a lifestyle perspective. For example,

> ... Of what help is Mimbo [drinks-alcohol]? If you eat things and they worry (nuisance), you stop. Europeans don't drink beer but they produce and send to us, so we drink and have *Shugar*.
>
> (Dr Ayissi, traditional healer in Biyem-Assi, 28 February 2003).

Traditional healers in Bafut were almost, inevitably, likely to know more of the family circumstances of their clientele than their equivalents, amidst the greater anonymity of

the city. How did that affect the diagnostic techniques and practice of healers in the two settings? The familiarity with links between diabetes and diet, displayed in the quote above, and even the idiom of lifestyle more generally, is more pronounced in the city. Often it has been acquired as a result of interaction with other health workers and through the media. And it gains in saliency in the city precisely because here patients' social background is less likely to be known. Moreover, some healers appear anxious not to offend patients who hold beliefs other than theirs. For their own repute, what traditional healers reveal in their diagnosis must be plausible and acceptable to patients and families.

Nonetheless, for traditional healers, as for the population at large, diabetes is still a relatively 'new' disease. For example, a traditional healer declared, 'This *Nighoni-Shugar* never existed. It is new. The "Whiteman (Europeans)" brought it.' The signs and symptoms diagnosed as diabetes had been known previously as different illness entities. Now, in a paradoxical way, the diagnosis and explanations given by traditional healers can help to confirm and reinforce biomedical diagnosis. This does not mean that diabetes never existed in Cameroon before. It simply explains the technological innovations that have taken place and made available alternative ways of diagnosing and explaining those symptoms that are indicators of diabetes. As seen with the taxonomy and idioms of diabetes in Chapter VII, diabetes is considered 'new' because previously different local names went unlinked to a condition where different symptoms are tied together and associated as diabetes.

However, supernatural explanations are one of the main ways that traditional healers approach diabetes. I start by examining cases where traditional healers (or their

clientele) have cause to believe that witchcraft has precipitated the onset of diabetes. It is common to hear some traditional healers both in town and villages conclude their diagnosis as follows, 'Your diabetes was thrown on you by witches'.

First, it is important to clarify what it meant by witchcraft and the terminology most typically used in Bafut and Biyem-Assi. Witchcraft in Cameroon colloquially means doing evil or something out of the ordinary with intent to harm. It is anti-social. Witchcraft more precisely means the use of some special powers inherent in persons, or the co-opting of spiritual entities, or the manipulation of substances – in each case to cause harm to others. Traditional healers typically interpret the motive of witchcraft as resulting from jealousy in Bafut, while in addition in Biyem-Assi some saw it as a show of strength by certain people. In Cameroon, sorcery is never distinguished from witchcraft except in the use of words in English and French, where witchcraft in English means *sorcélerie* in French and is quickly understood as such. One consequence of all this is that the distinction between witchcraft and sorcery made famous in anthropology by Evans-Pritchard (1937) on the basis of his fieldwork among the Azande does not hold in Cameroon.

Traditional healers interpret some witchcraft practices relating to diabetes in terms of either direct or indirect aetiologies. For example, some healers claim that diabetes was 'put into the skin' of a victim, like one receives an intravenous injection or vaccine. Some explanations hold that witches visit people in the night and introduce diabetes into their bodies through mysterious sexual intercourse, feeding them with some food or engaging the victims in a fight that ends up with the introduction of diabetes (see opening quote of this chapter). All these events are believed to occur as dreams.

This is an appropriate place to discuss the relationship between diabetes and sexual functioning, including the notion of diabetes as, in the eyes of some people, a sexually transmitted disease. The connection between witchcraft, sex and diabetes is quite a commonplace one (as the opening quote of this chapter shows). The belief in transmitting diabetes through involuntary sexual intercourse illustrated in a dream points to two issues. Firstly, that traditional healers interpret some incidents of wet dreams to mean witchcraft. Secondly, traditional healers build on what patients tell them to interpret the cause of their illness. From the opening quote, the suggestion is that witchcraft may inflict harm and suffering in a person by laying poisonous medicines containing diabetes across the road or at a junction where the victim regularly passes. This poison 'eats' (penetrates) the victim until s/he becomes vulnerable and develops diabetes. At times the traditional healers interpret the origin of the poison carrying diabetes to be from an unidentified illness which may – for men – be in the form of erectile dysfunction. Alhadji explained how poison laid on a path caused 'lack of manpower' (erectile dysfunction) in a patient, who later developed diabetes. In addition, the gradual growth of understanding about routes of transmission in the case of the HIV/AIDS epidemic has led some people also to think that diabetes can be transmissible. For example, a spouse to one of my patients complained, 'My husband told me that I am responsible for his diabetes; that I gave him through sex. I don't know if diabetes is also sexually transmitted'. It is difficult to tell if the sexual transmission the husband talked about was at root a witchcraft accusation (with his wife as the pathway for malign attack) or whether he really meant that his wife, who was not diabetic herself, contaminated him. But it does illustrate

some of the ways in which the understanding of the causes of diabetes has become bound up with certain ideas about sex and transmission.

The ordinary use of the word 'witchcraft' encompasses local Bafut terms like *Ndeme,* conveying the notion of chopping something. Any complications that emerge from diabetes are explained in terms of the witch eating deeply into the victim's body and mystically chopping and pulling out some organs like the heart, genitals, vision and nerves. Connotations in Biyem-Assi follow similar lines, but using different linguistic idioms particular to the ethnic groups. For example, the Ewondo describe witchcraft as *Evur* and the Bassa and Douala as *Ewusu,* all meaning to mystically chop a person. Traditional healers refer to witchcraft practices like *Nyoungo*[2] and *Musong*[3] in divining diabetes. Idioms are as diverse as the ethnic groups that make up Biyem-Assi, making it difficult to discern a single common pattern of meaning and explanation; but 'chopping' remains the commonest imagery.

Far from declining in relevance, the idea of witchcraft gets elaborated further in traditional descriptions and explanations of diabetes. Traditional healers in Biyem-Assi, for example, also explain the fact that one can develop diabetes after a threat from another person. For example, should an ill-intentioned woman cook food and call your name saying, 'You will have diabetes', that itself can trigger diabetes should you then eat the food. No poison but the mere use of words is sufficient to cause

[2] Nyoungo is an urban-based group of witches and witchcraft practices.
[3] Musong refers to invisible illnesses which people believe belong to the Bassa people. A non Bassa can purchase it or contact a Bassa man to use it in sending a disease to somebody. At times, when diabetes is as yet undiagnosed, traditional healers simply refer to the ill health of a person, which may manifest in the form of signs or symptoms of diabetes as *Musong.*

diabetes. What traditional healers meant here was to emphasise the evil that words can cause when wrongly used, portraying the strength of speech in everyday life.

There is a strong belief about a type of witchcraft called *Musong* already mentioned above. Though this type of witchcraft is more of an urban phenomenon, its origin is believed to be from the Bassa people. If a traditional healer in Biyem-Assi does not succeed in deciphering the 'cause' of diabetes in a person, he may attribute it to *Musong,* making his client understand that hospitals cannot cure it. It is believed that through *Musong,* diabetes can be sent to a person either to settle scores or just out of jealousy. In one sense, *Musong* becomes a catch-all explanation where other explanations are not found; but I also learned of individuals being referred on to those specialised in treating diabetes caused by *Musong*, though I never had any contacts to follow up this line of enquiry myself.

As indicated already, there are plenty of traditional healers in Biyem-Assi who distance themselves from causation in terms of witchcraft, and are scornful of those healers whose appeal lies in that direction. Yet such disdain should not betaken to extend to disdain for all mystical-type causation, as the following two remarks indicate.

> ...If you neglect *country fashion* [traditional rites/culture] and your parents become angry with you, then you feel guilty, it will affected you. But if you respect it and you perform the rites, you will be free...
>
> 'Dr Kuma, Traditional healer in Yaounde, 22 June 2003'

The importance of attending to parents (and beyond them ancestors) is invariably stressed, and neglected relationships seen as a cause of anger which in turn can lead to

a chronic condition like diabetes. But as soon as conflict is resolved (with appropriate ritual acts), the obstacle to curing the diabetes through treatment would be removed:

> ...When I talk of traditional rites, you need to perform them in order to be free. You make them for your parents, with much food, for people to eat. If not, you will be in trouble. That is, when a disease like diabetes catches (affects) you, it is ill–luck (misfortune). Go and bring down your father's box if you are the successor, and you will be successful in curing yourself. You cannot be a successor and sell a house with women inside and expect your parents to leave you free. You will have ill luck through diabetes or even die suddenly. That is why you find some successors who are always sick and poor.
> (Dr Kuma, Traditional healer in Yaounde, 12 June 2003)

But who are envisaged as witches, and how do they operate? It is important to emphasise that in Bafut, it is highly unusual for witchcraft to be imagined as coming from within the immediate family or among close kin, on either the paternal or maternal side. But although witches are imagined as non-family members, connections might in practice be found, for when witchcraft is diagnosed the witch is likely to be identified as a member of the local community. Nevertheless, the idea that witchcraft might come from within the family is resisted in Bafut, as it is with other Grassfield people (e.g. Pool 1995; Gufler 2003). Where family members are caught up, they are envisaged in theory more as innocent facilitators in the 'throwing' of diabetes. To have those who are expected to assist in finding treatment and cure involved on the 'other' side is too problematic to contemplate as anything other than an aberration. People in Biyem-Assi have similar assumptions. However, the physical separation of family makes it easier to contemplate the possibility that a family member living back in the village might be implicated in witchcraft.

To understand the ways, in which witchcraft is thought to produce diabetes, it is necessary to also understand ideas about vulnerability, which is expressed particularly in the idiom of blood. I move on to discuss notions of 'weak blood' and 'strong

blood', and the connections to hypertension and low and high blood sugar levels. The following quote illustrates some salient notions:

> ...People with weak blood are easily affected by diabetes because it passes in without any problem, but if you have strong blood, it will be difficult for diabetes to affect you because it protects you...
>
> (Dr Tumasang, traditional healer in Bafut, 11 March 2003)

The crucial and common idea here is that a person believed to have 'weak blood' is more vulnerable to developing diabetes than one who has 'strong blood'. Traditional healers often speak of 'weak blood' or 'strong blood' in securing the commitment and confidence of their patients. To be told that you have 'weak blood' is to be diagnosed as vulnerable. Many traditional healers hold that the mere fact of having *high blood*[4] [much and abundant blood], can prevent diabetes from being introduced into a person through witchcraft. The view is held in the community that high blood is a sign of strength, so traditional healers interpret weak and strong blood from this foundation. This notion of 'high blood' is not equated with hypertension but with 'strong blood' or high volume of blood. But it is seen as the equivalent of a certain immunity to disease, and hence to diabetes penetrating your body; especially when reference is made to witchcraft. An individual is said to be free from harm when he has high blood/ strong blood. Traditional healers think that a person with low blood has 'weak blood'. Again, 'low blood' is not equated with hypotension but with the fact that the person is vulnerable to illness, especially a chronic one like diabetes. People with weak blood are very vulnerable to evil, poison or witchcraft. The healers explain that a person with weak blood is predisposed to being 'shot' with diabetes because he has weak blood. For example an Indian bamboo poisoned with diabetes can be placed on

the road and a person with weak blood, not necessarily the targeted person, can pass by and will be affected. Whereas, another individual with strong blood, including perhaps the targeted person, could pass where the bamboo lay, step on it and yet remain unaffected. Having high blood and high blood sugar is interpreted as sufficient strength and protection from evil. Controlling it to a lower level means exposing and predisposing the person to illness. Furthermore, having high blood sugar is also equated with wellbeing, and reducing it is considered to expose an individual to having diabetes. Traditional healers' interpretation of 'strong' and 'weak blood' reveals personality conflicts leading to strength and weakness. It expresses some sort of power relations between patients and their healers and other people in the community. Patients and families, when narrated stories about 'strong' and 'weak blood', understand that they have 'weak blood'; that is therefore why they are 'bewitched' with diabetes.

A second very widespread explanation for a person becoming diabetic – and a more common explanation in the city than witchcraft – is said to be due to the influence of ancestors, whose intervention is to draw attention to unacknowledged conflict within the extended family or the lineage of the patient. Problems surrounding succession and inheritance are repeatedly diagnosed by traditional healers as the most likely to occur, although these are not the only kind of family problems. In local understandings, a problem like succession struggles predisposes a family to be vulnerable to diabetes. It is widely held that once a family had problems they should resolve them instantly to avoid the involvement of outsiders. The coincidences of a

[4] The high blood in this case is not hypertension but reference to the volume and strength of blood in a person.

family history of diabetes and problems of succession are widely interpreted in terms of neglect of, or occasionally outright disobedience to, the ancestors.

How is diabetes thought to find its victim? When succession (inheritance) and other misunderstandings erupt, diabetes enters a member of the family, and remains until the conflict is resolved. Moreover, some healers argue that it can become a family disease if diagnosis and healing delay. Traditional healers believe that such a problem, when resolved, facilitates the cure for diabetes. It may be that another succession ceremony, referred to as 'a proper succession ceremony' gets advised. And by 'proper' they mean that the family should gather, enter into dialogue with one another, and iron out any lingering conflict or disagreement. Such ceremonies go with spending exorbitant sums of money in feeding people as a means of pleasing ancestors.

Yet there remains the problem of explaining why the patient does not get better – why diabetes persists – after these conflicts have been resolved? Partly to play safe and avoid being accused of incompetence, traditional healers generally explained to their clients that diabetes is more easily 'cured' if discovered and treated at an early stage. Delays in diagnosis, and delays in conflict resolution, could easily accentuate the illness and disease, making it that much more difficult to treat and cure. Thus these healers protect the internal coherence of their own system of knowledge and practice.

But the key point here is that diabetes is recognised to have a family history – even if not what the clinic would mean by 'family history'. Family history here is unrelated to the biomedical idiom but is paradoxically just as important as within biomedicine.

Instead, it is the interpretation of certain conflicts and frustrations that may date back several previous generations. Admitting the possibility of ancestral wrath shapes the interpretation that diabetes is a family illness. Failure to pay bride price and making partial succession decisions paves the way for diabetes within someone in the family. Chronic diseases – and of course diabetes is only one of many, though rapidly becoming more prominent – are therefore regulatory in function, used to mete out justice and call people to order in a fashion that reemphasises family history.

While 'curing' the problem of witchcraft is done quietly, with no show, the 'curing' of ancestral disapproval usually involves a very public display that good relations are being restored. The secrecy involved in curing witchcraft is to avoid public awareness that the patient has been freed of witchcraft and to ensure that there is no future reoccurrence. Revealing that the chains of witchcraft have been released can be tantamount to reinforcing it and making diabetes too complicated to cure. But the ceremonies observed in issues relating to ancestors are very public manifestations that bring families to terms after a conflict has been resolved. It is indeed the ritual and celebration which performs the cleansing through which families are reintegrated and restored to harmony.

A third type of explanation for diabetes offered by a minority of traditional healers currently revolves around factors making for an 'unhealthy lifestyle': diet, alcohol consumption, smoking, physical exercise, for example. Yet, as I have mentioned already, this framework of causation is rarely seen as sufficient explanation in itself – if it is even advanced in the first place. Whether it is depends largely on how exposed traditional practitioners have been to biomedicine. Either diet may, as already

indicated, be seen as one causal factor in a chain of causation – but not in itself a crucial or underlying cause. Or, alternatively, diet may even be actively construed in contrast to modern public health advice, inasmuch as what clinics label 'unhealthy lifestyles' may easily be considered as healthy – and therefore unlikely to trigger disease and ill-health. The example of the benefits of Guinness, mentioned in the last chapter, illustrate the point.

The crucial point to emphasise in this section is that, whatever diagnosis was given by a traditional healer, he invariably insisted that diabetes was curable. The patient *could* recover, and thus it would not necessarily be a matter of managing diabetes for the rest of one's life. Whether the patient *would* recover was conditional on numerous factors, but in principle recovery was achievable when the ultimate cause was properly addressed. Asserting a cure for diabetes as traditional healers do was not a mere declaration, but should also be understood as a way to show strength as a healer, for the credibility and reputation of healers rested on the twin foundations of their capacity to diagnose and their capacity to cure. But in addition, we have to appreciate that the western notion of the 'chronic condition' has hitherto had little currency in Cameroonian and indeed West African cultures.

Traditional healers stand out moreover as important sources of information to families and the community. Not only do they have an influence over many people in terms of knowledge; they also have the power to interpret and manipulate the knowledge in their practice.

8.4 Healing practice: carrying conviction for patients

> ...I cook medicine with that one... I use the country pot [clay pot] to wash people and cook medicine. When somebody is to wash during treatment, I put his water inside. That one (clay pot) with feathers is to protect this place. If you do not do that, enemies will block (disable) your place, and you will not more have customers (clients). So when you do that and they want to block, they will not get you. I use the calabash there with bottles inside as my lab...This (clay pot) is stronger than the other, because when I want to work (perform a healing ritual), the person stands this way and I stand that way. When it is strong (difficult) on this side, I send the person to that side. At times when you look on this side you discover that the person is blocked; so you have to move to the other side, to see the sick (illness)... Inside (the water in clay pot), you see the people who always come and tell me a person's illness, so when I look like that they will tell me. That is how I know what a patient is sick with... Yes! You cannot see but if your eyes[5] are washed you can see. When bad things (evil spirits) are disturbing you in the compound and I come and work [heal] you, I take that bag hanging there and wipe you with. You will be sleeping and not hearing those bad things again. Then these two spears you see, I use them to search for a person to treat (cure or heal) in a difficult situation. To remove you from a society [sect], I work (perform the ritual) you at that end, then I send you and cover you. This is the head of a quake' (monkey)...
>
> (Dr Ngwa, Traditional healer in Bafut, 28 February 2003).

In this section I look more closely at how certain traditional healers work. My purpose is not simply descriptive, to document practices. More important, it is to convey how and why their practice can appear convincing to their clientele. Bear in mind that most clients will also have been to clinics. They have, therefore, an alternative regime of treatment that they could rely upon. But many choose not to do so, preferring either to alternate between two (or more) regimes, or to combine the two, or even to rely largely on traditional practitioners. To the clinics, this is simply irrational behaviour; evidence of the hold 'superstition' has on many people. But to those concerned, consulting their chosen traditional healer seems a sensible course of action, as I explored in the last chapter.

[5] Washing eyes. It is not the washing of eyes but it is rather the washing of the face. At times some water will be thrown into your eyes.

But what does a traditional healer do to appear convincing, plausible, and trustworthy to his clientele? The traditional healer uses an array of techniques to attract patients and maintain his relationship with them and their families. He uses methods both credible and acceptable to people that visit him. Being part of the social world where patients live, he knows much about the conflicts between people and how people understand and interpret the world of illness. The previous section examined this in some detail.

But in addition, I encountered a certain number of traditional healers – in both settings – who have probed into the world of biomedicine, adding to their repertoire of knowledge about treatment and care for patients. This seems to be precisely to enhance their own explanations and practice, to make these the more convincing, given the numbers of clients/ patients who move between these two alternative frameworks of medicine. In such cases it is the complementarity of biomedicine and traditional healing that the practitioner is willing to emphasise – unlike his clinic counterparts for whom the notion of such complementarity is anathema. In essence, these healers not only distance themselves from those other healers whom they regard as dealing in superstition, but they also stress both their own 'modernity' and their capacity to offer something that extends and builds on the (limited) therapies available through the clinic. These practitioners thus position themselves very cleverly in a crowded healing 'market-place', trying simultaneously to 'outbid' both the clinics and those they regard as the more backward of fellow healers. Enhancing credibility is

often done for these healers moreover by using biomedical clinics to validate their diagnosis. One declared, 'We always send our diabetes to the clinics to verify the evolution of the treatment that they get from us.'

A traditional healer always asks questions to his diabetic client or other family members, and much of his persuasiveness rests on producing an explanation in the end, which makes sense to his client. The healer draws upon familiar and widely understood symbols in his consultations, as the quote opening this section illustrates. Such symbols are the core of the messages that traditional healers relay to patients. (For parallels, cf. the *Spider divination of the Mambila and Yamba* described by Zeitlyn (1998) and Gufler (2003).)

8.5 Relationships between traditional healers and clinic staff

> ...If a patient is above (beyond) the hospital doctors, they should send (refer) him to traditional doctors. The faith patients have in doctors is also important because when a patient meets a doctor he starts feeling fine (well). The way you receive a patient also matters. We don't refuse patients because of money. Medical doctors always ask for tests so as to be able to treat. Others just go into giving treatment without testing. Medicines work according to blood. We need to work hand in hand (collaborate) because the medical doctor can even contact us when the patient is in hospital. It will be good for us to co-operate. But medical doctors say they can't co-operate because they say the government has not recognised traditional doctors. Some of them even come to us, take drugs privately and use them in treating their patients. We (traditional doctors) do not also co-operate because they exploit us to learn our leaves. When we go to meetings, they don't pay us. They discriminate against us. The government does not encourage us to work...
>
> (Dr Kadjob Traditional healers - 52 years - in Biyem-Assi, 16 October 2001).

The passage, quoted above, contains two themes relevant to the discussion in this section. Firstly, the existence of some sort of relationship between traditional healers and 'medical doctors' or the modern medical system. Secondly, reciprocating modern

medicine's suspicion of traditional healing we find scepticism on the part of traditional healers about the competence of some doctors and the limitations to their knowledge.

In this section, I consider these themes. In Chapter VI, I gave an indication of the hostility of clinic staff attitudes towards traditional healers, and their disparagement of virtually all such healers. From talking to these staff we might imagine there is no room for contact and communication across such a fundamental divide. Yet, that is not quite how it seems from the perspective of traditional healers, and in this section, I want to explore how these healers view the modern clinic, its practitioners, and its treatment.

On the one hand, from the above quote it appears that traditional healers view clinic staff with much of the same suspicion as they receive from clinics (as we saw in Chapter VI). On the other hand, while it is hard to generalise about so many varieties of traditional healers in this context, a number of those healers I spoke to and got to know clearly do reflect on the relationship between their practice and that of the modern medical system, and even in some cases envisage its enhancement. They are not entirely alone in this, for there have been occasional efforts by government in recent years to bring at least what they regard as the 'respectable' end of the traditional healing spectrum under the aegis of the Ministry of Health (MOH) control. Government has enacted legislation and restructured the organisation of the MOH creating a service for traditional medicines. The services have been created to respond to calls for the recognition of traditional medicine and for their eventual integration into the medical system. The function of this service has been to regulate traditional

medical practices in Cameroon. However, to the dislike of many traditional healers, the service has concentrated in encouraging the formation of traditional healers' associations rather than facilitating their integration into hospitals. This has actually provoked traditional healers to treat most government action – and even calls to participate in seminars for example – with suspicion, and led to heightened hostility rather than rapprochement with medical doctors. The conflict existing between these two medical paradigms of knowledge and institutional worlds of practice has seemingly succeeded in driving a further wedge between traditional healers and biomedical practitioners. At lower levels a rather different story emerges.

In its most demonstrable form, this engagement – perhaps better seen as collusion – is played out in the hospital setting itself, always under cover of darkness. For once in a while a traditional healer may be called in by patients' families (or even by low-ranking hospital staff) to administer treatment in the ward. Invariably, such illicit visits take place by night. There are two reasons for this. Most obviously, such visits can only occur when no senior medical staff are on duty, for they would not countenance such a course of action. But also it is at night that witches are prone to visit patients to accentuate the suffering and thwart any treatment being offered. But if the family members propose this course of action, and the relatively junior night-duty staff more or less willingly accept it, it is because of a shared popular understanding that certain aspects of the patient's illness can best – or only – be tackled by the traditional approach. Families of very ill patients may well also think that the treatment offered in the hospital is inadequate and needs to be supplemented if the patient is to have a chance of improving.

I was myself surprised when I discovered that such night-time visitations took place. Moreover, because of my personal relationships with senior medical staff and the ANSA programme, it was highly unlikely that any hospital staff or patients would have volunteered insights about such occasions to me. Yet once I had shown myself open-minded and interested in the workings of traditional healers, and enquired about the contacts between the different spheres of medicine, it was not long before I was quietly told of such occasions, by patients and healers. Confirmation from one traditional healer in Bafut came with a smile, for he could hardly fail to enjoy the symbolism of such a subversive activity, through which formal hospital procedure was breached so spectacularly. Spheres which clinics strive to keep so sharply apart are not meant to be brought together in the manner conveyed by such practices. Their importance is also related to the severity of illness. No-one bothers to embark on such a risky and illicit venture – risky certainly for any staff who might be caught – unless a patient is considered to be very ill indeed, their life potentially in danger.

8.6 Traditional authority and the reproduction of knowledge about diabetes

> ...There are millions and millions of viruses that scientist have not yet discovered. Ancestors have their own peculiar diseases that could be cured. They have sent some, which we have not discovered how to cure. The doctors will be struggling all around but since they don't know the cause and effects of the diseases, they will be struggling and struggling. And yet, this is within the spirit of disease and within the control of the spirits of the ancestors; because they will put the disease and will at times make the doctors to either have a narrow discovery of the cure or unknown to modern medicine. They get only a virus which is undiscovered to modern medicine, so the spirit can be using it now to punish those who have disrespected them. And this is the same thing with this diabetes. When once you succeed and they still have other viruses undiscovered, they go and bring out other undiscovered viruses and send. So, that is why when scientists are writing on things like this they should always give an allowance for those who know the cure. They are all the facts about

> our diseases and that is why I must respect tradition everywhere and at anytime. When you don't respect tradition, you will not live long. That is why a tyrant or dictator, call them tyrant or dictator, when you are wicked to your people and they have no means of deposing you, the ancestors will hear their voices and they will send these incurable diseases which will infect you and do away with you. That is why I make sure that I respect my people, my ancestors because living beings can cry and the ancestors will hear them and send these incurable diseases...
>
> (*Fon* Abumbi II, King of Bafut – 8 February 2003).

This final section relates to Bafut alone. It seeks to place in context the tenacity of traditional forms of knowledge there. How does an understanding of attitudes to diabetes in Bafut lead us to the *Fon* and the traditional structures of the Bafut kingdom? And why are the *Fon*'s own views about diabetes, touched on in the extract above, relevant to this study? The *Fon* is an incarnation of Bafut society, a *primus inter pares*. He is considered as the most knowledgeable about Bafut culture. He has a final say in the resolution of conflict among his subjects, and he represents ancestors of the kingdom. Being superior to all persons in the kingdom, his authority and decisions are not supposed to be opposed.

We have seen already that one of the commonest 'causes' of diabetes, in local belief, has to do with succession and a disruption of the harmony in family matters that ancestors are believed to guard. On a small scale, this echoes the role of the *Fon* and the political-ritual institutions of the kingdom. But more than this, the *Fon* has the power and responsibility to protect Bafut from disease and to cleanse his subjects when disease and illness strike. The traditional institutions of the Bafut kingdom – including the ritual duties of the *Fon* and the operation of Bafut's secret societies – have an overarching aim of securing health and wellbeing. The platforms that the *Fon* uses for ritual performances are both public and secret shrines scattered over the

kingdom. The rituals performed during the *Takumbeng* and *Abin-a-Nfor* ceremonies are examples of how the *Fon* through rites ensures the cleansing of the Bafut kingdom, and maintains harmony with the ancestors collectively. What would happen if traditional powers like the *Kwifor* (see figure 20 – Mabuh), *Takumbeng* and *Fon*, did not perform their roles? What would happen if a person was disrespectful to tradition, elders and ancestors? In a word misfortune, where illness and disease provide the primary examples of misfortune.

Figure 20: Mabuu [Kwifor messenger]

The *Fon* articulates a view that easily allows a synthesis of 'modern' and 'traditional' medical knowledge. He has given his backing unstintingly to clinic initiatives to combat the rise in the incidence of diabetes. But at the same time his is a view in which perceived limitations in medicine or medical science only help point to explanations found within traditional knowledge. In this way, the *Fon* articulates a framework of thought that, while outwardly and publicly supportive of biomedicine,

nevertheless tacitly shares much in common with that of traditional healers. The *Fon*'s position can be understood from the fact that he represents the people that he governs. His articulation of a rich tradition of Bafut knowledge links family events to an explicit and shared worldview in which the wellbeing of Bafut as a whole is embraced. Thus it is not only traditional healers and the mass of the population who talk in terms of the punishment that neglected ancestors may inflict through a disease like diabetes. It is the *Fon* himself, the fount of Bafut wisdom and divinely sanctioned authority, who insists on this fundamental truth. He is perceived by his subjects to talk knowledgeably about science; but he also places an implied question mark of doubt against science's competence and claims. And – in line with tradition – he finds the language to insist with authority that all diseases have a cure. If biomedicine states that diabetes is a condition that has no cure, the *Fon* reminds us that this is simply because the ancestors have not yet revealed the cure. In his own words: 'The cure of diabetes resides in the world of ancestors and when you settled the conflict that you have with them they come to you in a dream and point to the part of the forest where you can go and discover the medicines.' Note here the reference to the forest, the source of spiritual and ancestral knowledge – but only to those who respect tradition and ancestors alike. In this worldview, the relationship between the millions of viruses which exist, specific diseases, and practical cures is ultimately in the hands of ancestors and tradition, and modern science and biomedicine, even if their practitioners do not grasp this reality, can only exist within these parameters.

The passing of each year is marked by rituals, with a ritual cycle in which each rite has a set time. These rituals are performed to purify the kingdom and protect it from

disease especially at the approach of the dry and rainy season. The *Takumbeng* ritual[6], *Abin-a-Nfor*[7], the ritual to mark the beginning of the year, the planting ritual, grass cutting ritual, and harvest rituals, are the major occasions that characterise the ritual cycle. Apart from the birth[8], funeral and death celebrations rituals which are organised by families, the rest, except for the funerals of important palace descendants, are at a macro level, and therefore organised by the kingdom for the people of Bafut Kingdom. These rituals are organised and run by members of each of the arms of government within the kingdom as a way of respecting tradition. The *Takumbeng* organises the purification and protective rituals that help in preventing illness. And at the head of each of them is the *Fon*. He participates in each of these rituals as tradition warrants. The *Kwifor* specialises in ceremonies connected to cleansing defaulters of the land and especially ensuring the respect of tradition. Again, the *Fon* makes sure that things are done correctly. The *Fon*'s role is always central and by tradition he makes sure that the ancestors are satisfied to avoid their wrath (see rituals on figure 20 and figure 21).

As the most important person in Bafut ritual life, the *Fon* initiates his own actions to prevent more people from being infected by diabetes and does all he can to please the ancestors. 'These rituals are our own ways of preventing illness', he stated. One of the requirements for him to avoid the wrath of the ancestors was to feed the people of Bafut. On every *Moumetaah* (country Sunday), one quarter of the kingdom visits the palace with food and firewood. This wood is used to 'keep fire on' in the *Achum*[9].

[6] Takumbeng ritual is the ritual performed by the traditional institution called *Takumbeng*.
[7] Abin-a-Nfor ritual is the annual dance ritual.
[8] Most of the birth rituals had to do with rituals of integrating twins into families and giving them their due spiritual powers.
[9] Achum is a gigantic traditional building the palace, believed to be the lodge for ancestral spirits. Fire burns inside the Achum all the time. The building is said to be constructed around the 17th Century.

Out of this complex of traditions and elaborate ritual, the 'incurability' of diabetes can be made sense of within a traditional frame of reference. And the *Fon* protects his subjects by representing them before the ancestors.

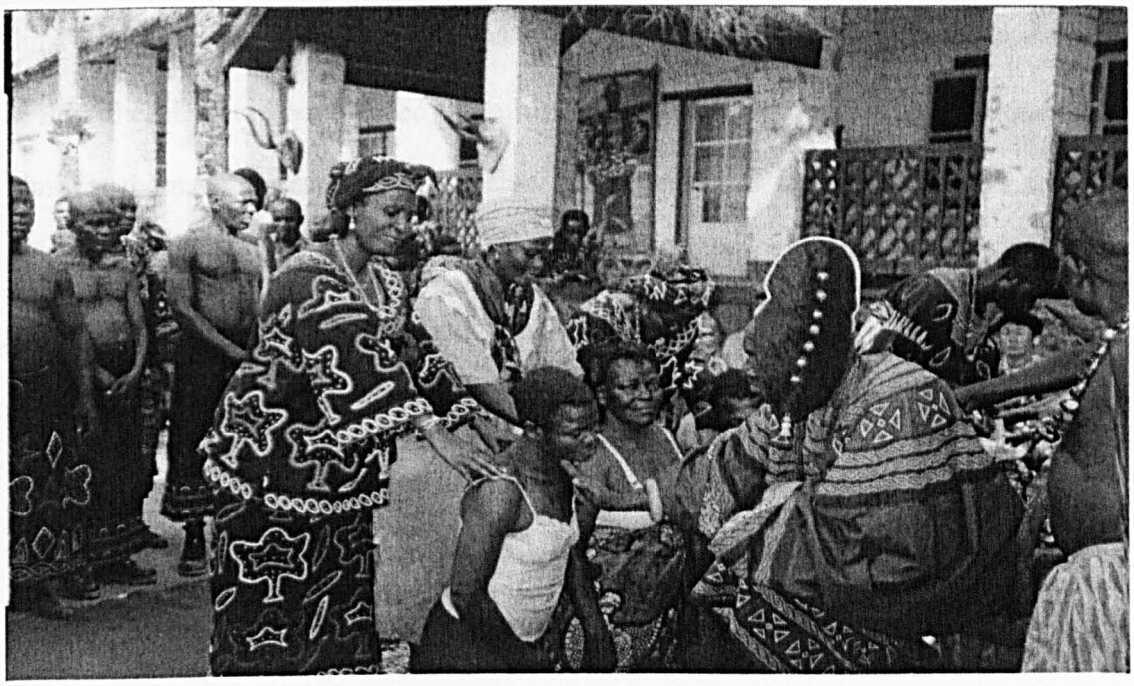


Figure 21: *Fon* of Bafut performing a succession ritual

Figure 22: Princesses in Bafut process into *Achum* to perform a ritual Figure

8.7 Conclusion

When I started this study it was not my intention to study traditional healers. But an anthropological approach requires the researcher to pay attention to the ways of thinking of those he studies. From that angle, if I had ignored the place of traditional healers then I would have failed to do justice to the ways in which patients and their families themselves respond to diabetes. My attention to traditional healers reflects the attention paid by patients and their families. But, to understand what this relationship offers diabetic patients and their families, it is necessary to make enquiries of the traditional healers themselves. That is what is reported in this chapter.

In this brief conclusion, I emphasise how I have elaborated the following major themes. Firstly, the implications of the widespread popular belief that all illnesses are ultimately curable. Secondly, the understanding of supernatural causation, whether involving witchcraft or more commonly ancestral influence, which in biomedical terms is tantamount to the externalisation of the causes of diabetes. And thirdly, the various ways in which 'traditional knowledge' is made convincing and reproduced in new circumstances.

In relation to this last theme, we need to set aside the mindset which sees biomedicine as inherently and automatically the most convincing medical regime wherever it gets established, and traditional medicine as crumbling gradually into irrelevance as evidence mounts against it. The evidence from my ethnography is that it is more complicated than that simple developmental model implies. Not only may biomedicine face particular scepticism in relation to a chronic disease like diabetes,

which needs careful management without a cure in sight. Equally, and linked to that, the capacity of 'traditional' healing to adapt and reinvent itself, as it absorbs new knowledge and discards what does no longer carry conviction, should not be underestimated. It shows us a regime continually reproducing itself to remain relevant. Only when it ossifies and ceases to change will it disappear, or become a matter of heritage and history.

I have analysed the traditional medical practices I encountered not arguing about their scientific basis as opposed to "western medical practices" but in terms of the ways in which they work on the ground, as persuasive or not-so-persuasive frameworks of knowledge and understanding. For any system of healing and medicine has to be convincing to its clients. And modern biomedicine, its clinics and hospitals, cannot ignore the continuing vitality or tenacity of what for convenience I have – following others – labelled as 'traditional healing'. These two regimes of treatment entail different kinds of performance and different kinds of assumption. I have tried in these three chapters to lay out these differences, and the points where they intersect. Traditional medicine in Cameroon, especially in relation to non-communicable diseases like diabetes, has not received very much attention from social scientists. It has been infectious diseases which have received what limited anthropological and sociological attention has been given (see Pool 1994, Ryan 1998). Yet the story surrounding the adjustment to the burden of diabetes – both an individual or family burden and a national public health burden – is just as important in the long run. I believe my ethnography provides a start in this task.

Chapter IX

Conclusion

This project has evolved in a way that reflects its origin in a public health programme and its conclusion in medical anthropology. The original purpose was to study intensively how a diabetes programme could work more effectively. In a country where diabetes is increasingly being recognised as a growing public health burden, there is considerable concern that public (or more precisely, patient) responses do not sufficiently grasp the gravity of the disease and its implications. This concern not only lies behind the desire to initiate this PhD, it also expresses itself in a refrain that has surfaced and resurfaced throughout this study, voiced repeatedly by clinic staff: 'non-compliance' among patients. Non-compliance is one of those major themes of reflection in this concluding chapter, the other two being aetiology and power.

This study, therefore, started out as a study of 'non-compliance', and it is for this reason that the first of the main ethnographic chapters, Chapter VI, takes the perspective of the clinic. Chapter VI provides an understanding of the rationale behind clinic practices, the differences of emphasis and approach between clinics and within them, and the attitudes, assumptions and expectations made about patients and their families by clinic staff. The prevailing picture is of patients failing to measure up to the treatment/management regimes proposed by clinics. Also, the family is excluded from the management aspects of the clinics.

Yet the clinic perception is of course not a good guide to patients' own understanding, and the journey taken in fieldwork, moving beyond and away from a solely biomedical perspective, is reflected in the two following ethnographic chapters: VII and VIII. Central to the argument of these chapters are two observations. First, that biomedical knowledge constructing diabetes as a disease that can be managed but not at present

cured comes up against deeply held lay understandings that diabetes, like most other diseases, can be cured. And second, following from that, patients and their families are predisposed to look beyond the limited (and costly) appeal of the biomedical model to embrace simultaneously the promise of cure held out by traditional medicine. Where the clinic demands exclusive compliance and adherence, the patient, their families and traditional healers themselves ignore such exclusivity and assume no fundamental problem in combining therapeutic possibilities. In this way, clinic expectations and exhortations are subverted at the outset.

It is important to emphasise that those who use combined therapeutic treatment value the clinics. The clinics are not disparaged or ignored, but respected. Yet that in itself is not sufficient to ensure that the treatment and disease management stipulated by clinics are followed. For the somatic causation offered by clinic staff, however convincing to those working within biomedicine, is not convincing enough for many (indeed most) Cameroonians faced with diabetes. Not only is no cure proposed as possible, not only is dietary advice often perceived as contradictory; the ultimate social explanation for individual vulnerability is something biomedical causation has nothing to say about. So long as Cameroonians assume - indeed know - that there are social causes behind illness and disease striking individuals, and that harm is manifested through 'mystical' or 'psychic' means like witchcraft, then specialists in such diagnosis and protection will continue to have a part to play, supplementing whatever clinics are available. This therefore justifies why I made a shift from a purely medical focus to the wider society.

Besides the shift from a solely medical focus, another challenge, reflected in this ethnography, relates to an expectation previously held. That is, the assumption that

rural and urban populations were likely to be different in their ways of tackling diabetes. This assumption turned out to be largely mistaken. Urban and rural areas are similar in most of the causal theories that they construct. There are two assumptions to address here. Firstly, the assumption that the higher level of health facilities in urban areas might encourage city people to use them more than rural people would do. Secondly, the assumptions that the higher academic and professional backgrounds of people in the towns would lead them to think differently; favour the use of modern health facilities; and appreciate the occurrence of diabetes differently. This does not seem to be the case because the alternative quest for a cure for diabetes obtains for both rural and urban people. Indeed, those who combine treatment do so as a means of not missing out any healing opportunity. The analyses reveal how pursuing popular knowledge and understanding lead on to ethnographic insights about food, drink and sex both in Bafut and Yaounde.

Talking about food and drink, and following from clinic prescriptions, patients are required to maintain a 'healthy lifestyle' by controlling their feeding habits and alcohol intake. It also requires checking weight gain. But many patients and their families interpret this in unintended ways, since weight loss is popularly equated with poor and insufficient health care. Being overweight is a highly recommended local sign of wellbeing in Cameroon as in most of Africa. For that reason, most people often take decisions to maintain or increase their weight rather than reduce it as a means of controlling diabetes. In this context, some alcoholic beverages like Guinness are preferred as being curative, and are taken in association with diabetes drugs, on the grounds that they cure diabetes. The resistance to changes in eating and drinking habits, by most people, is not because they are refusing to comply but because they are

compelled by their own underlying beliefs that the food and drinks they are meant to avoid actually include some which assist their wellbeing. Non-compliance stands out as an important issue in western public health debates about diabetes so the issue is not confined to clinics in Cameroon. However, health care practices in Africa are different, to the extent that non-compliance is a concept unknown to many people and activities interpreted as such are understood by the subjects of my study as reasonable explorations of all opportunities that can cure diabetes.

Obviously I did not initially foresee that a discussion about diabetes would go beyond the clinic, taking a journey into the wider social world. But I extended my work to the families and traditional healers to be able to draw a distinction between what the clinics presented and how diabetes is managed in the wider social realm. It turned out that family intervention and traditional approaches to treating diabetes remain highly valued. If people think that in Biyem-Assi traditional healers would be disappearing with the onset of modern medicine, they are misled.

However, the actions interpreted by clinic staff as non-compliant emerge from the meanings made of the underlying aetiologies, the second theme that cuts across this ethnography. For example, while the clinics talk about sex as a complication of diabetes, people understand it to be a pathway for the transmission of diabetes. The issue of sex reflects the understanding that diabetes is transmissible. This may be as a result of the high prevalence and awareness of HIV/AIDS, and the understanding that diseases acquired through sex can be difficult to cure. This is quite different from the clinic standpoint where sexual dysfunction is understood as being a complication of

diabetes. But it has to do with the cultural beliefs prevalent in daily discourses around witchcraft.

The aspect of sex and diabetes was one issue which led towards the notion of witchcraft, one of the recurrent aspects within the construction of aetiology. Witchcraft is believed to cause diabetes when people are unable to explain and link any potential risk factors. Also, through diabetes, witchcraft is a way of revealing hidden conflicts between people in the Cameroonian community. Through witchcraft, people obtain solutions to social conflicts, a prerequisite for securing effective treatment outcomes from either modern or traditional clinics. Again, witchcraft is a result of fear as people live in fear of the harm and domination by witches.

Witchcraft is a broad catch-all term that only imperfectly describes the diversity and subtlety of local experiences in Africa and elsewhere. But according to Bond et al (1976, 1979, 2004), anthropologists are held back by their limited academic lexicon to fully understand and describe it. The views held by some authors merely express the paucity of information to describe this art and the beliefs about it. What I have illustrated in this thesis is the fact that witchcraft is an encompassing term pulling into its realm aspects of mystery, magic and the real or obvious things happening in African societies like Cameroon. English and Pidgin language speakers use witchcraft as a description of the totality of the different evils inflicted by one person on another. The term *sorcélerie* [sorcery] is used by French language speakers to denote witchcraft. When talking about witchcraft or *sorcélerie*, in local languages, these terms are used interchangeably as being witchcraft. Also, this ethnography illustrates that witchcraft is an aspect of power adjustment, exacerbating the feeling of vulnerability

to evil and culpability that can prompt the occurrence of chronic illness. Witchcraft therefore is an expression of fear and guilt.

The fear of witchcraft as a mystical force is compounded with the fear of ancestors, as superior supernatural (invisible) people who can cause harm (by introducing diabetes into the family) when dissatisfied with the living. For example, succession problems are believed to offend ancestors, who can punish family members that defy ancestral decisions. Many patients and families of diabetes associate the occurrence of diabetes with the breach of kinship relationships with ancestors. Besides succession, some irresponsible behaviour, like disobeying the ancestral will and neglecting weaker people (women, children, widows, the sick or handicapped) in some families is also associated with ancestral wrath and the occurrence of diabetes. However, ancestral beliefs related to diabetes also facilitate the resolution of conflicts. Similarly, it acts as an impetus for some people to return to seek care in the clinics, believing that they will have better outcomes. Ancestors figure in this ethnography, not simply as those who protect the family or tribe, but more as regulators of conflicts and assurers of social justice. This interpretation illustrates the weaknesses in the social and judicial order and the strength that beliefs in the supernatural have in shaping the paths that most people take to obtain treatment for diabetes in Cameroon.

One of the main assumptions which I set out with was the fact that adherence to traditional beliefs (witchcraft and ancestors for example) would be stronger in Bafut. But this turned out to be different. Instead, in Yaounde, if anything these traditional beliefs revealed themselves in a more magnified, transformed and reinforced manner. Many of these beliefs, though still keeping their original attributes, have been

modified as a result of contact with other traditional practices as well as modern biomedical ideas. These beliefs influence the causal theory construction and health-seeking behaviour pattern for diabetes in similar ways.

A third theme that runs through this thesis concerns power and its different guises. Power is expressed at the level of the clinic by the clinic staff who try to place patients in a dependent position, giving out instructions and wishing that they should be respected. But this also meets with some resistance as patients opt to act differently believing that they are not being understood, so are being inadequately cared for. However, the show of strength by the clinics is also viewed as weakness by patients, as they promise control and not a cure. Moreover, the clinics do not provide solutions to social vulnerability of patients or their families so are consequently considered weak, when compared with traditional healers. Traditional healers are repositories of power themselves. But so too are witchcraft and ancestors also sources of power. All help to determine the path taken by patients in their quest for seeking cure where the powers of witches can be countered. Those retaining these powers manipulate them, in ways that create fear and a feeling of vulnerability in patients and (possibly) families. Hence, a feeling of domination takes central stage and makes patients and families depend on the whims and caprices of those who pass for witches and ancestral representatives.

Several issues are worth understanding in the use of languages in this ethnography. Firstly, that using a single language in doing ethnography in multilingual communities in Africa, when studying an illness, restricts the possibilities of understanding the different networks of meanings. Therefore, doing ethnography in Cameroon, like

many other African countries, requires multilingual skills, especially in urban areas, to enable the anthropologist to grasp the depth of meaning in fieldwork encounters. If s/he fails to know other languages s/he will miss out much of the conversations and events required to enable him gain insights into his data. In that case s/he will be analysing second-hand ethnography, collected by others, and will therefore present less richly detailed findings. Secondly, rapid urbanisation and the spilling over of urban lifestyles to rural areas and vice versa preclude rural areas from being close societies where life is one-dimensional, and where one language predominate daily discourse about an illness.

My reason for doing a comparative ethnography has been to analyse and understand if people living in rural and urban areas share the same or have different ways of understanding and managing diabetes. This has been done with the initial expectation that the existence of many modern health care facilities in urban areas may encourage people to seek medical care for diabetes within these structures, without recourse to traditional medicine. But it turned out that traditional medical practices are highly valued as an integral part of diabetes care. Though there are differences, the similarities are more prominent than I initially expected, because people from villages reconstruct and reproduce their cultures in towns when they migrate there and act with inspiration from village values.

To the best off my knowledge, this ethnography, by its comparative nature, is original and has not been done elsewhere in sub-Sahara Africa, using the same approach to diabetes. Similar studies have been conducted on other health problems in Cameroon like kwashiorkor (Pool 1994), infertility (Feldman-Savelsberg 2002) and infectious

diseases (Ryan 1998); but this thesis is an unusual case with diabetes (a chronic illness). My thesis is also original because it begins an ethnographic focus on emerging chronic diseases in Africa, and compares urban and rural settings.

Finally, this research came out from epidemiology and public health so warrants that I conclude there. It is clear that the research indicates a need to understand and confront the issue of 'non-compliance' within the Cameroonian and general sub-Sahara African culture both in terms of clinic staff education and the careful orientation of patients and families embarking on clinic treatment for diabetes. By so doing, they can be made more aware of the contradictory nature of traditional thinking in respect of treatment regimes for biomedical management of diabetes.

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Glossary

Glossary

Word	Glossary
Bafut words	
Abin	Dance
Abin-a-Nfor	The Fon's Annual Dance
Achu	Pounded colocassia and well spiced soup prepared with oil and dried meat.
Allah	Referring to Muslim feasts, during which there is always much to eat and drink for all.
Atangcho	A who governs a village, which has the status of sub-chiefdom
Ayeunda	Ward
Biifii	People who have been enclosed
Bukums also called Ngang-Ngang	Specialist in the Abin-a-Nfor rituals
Butabunekuru	A council of elders or village heads that governs village
Camwood	Red paste used for rituals-obtained from a a tree called camwood
Chong	An assembly of princes, with functions to protect royalty and maintain the status quo, therefore part of the Fon's cabinet and not a power per se. They are his brothers and advice him on how the palace should be run.
Faay	***Nso word for successor***
Fon/Nfo	King
Fumbgwuang	Salt, diabetes
Kwifor	Judicial arm of traditional government with wide ranging powers, including the power to depose an ineffective or malfeasant Mfor [king].
Mabuu	A kwifor messenger
Mbaw-Abin	Build the dance ritual
Mfeenu	The pollution removal rite
Mfor	King
M'ma'abumwi	Placatory rite.
Moluh	Palmwine
Mou	Child
Moumala'a	Heart of the country clustered around the Fon's palace
Moumetaah	Country/Traditional Sunday
Mou-Ngang	Traditional healer
Muma	The Fon's junior brother, second in command
Mundeughe	Protective ropes lay across road junctions to protect Bafut from evil from other kingdoms.
Muntoh	Prince/Princess
Nchinda	Palace guard
Nda-Ngang	Medicine house, traditional clinic
Nde	Mum, Mother
Ndeme	Witchcraft
Ndéré	Takumbeng shrine
Nekuru	Village
Neubah	Monolith - A hut constructed at Nsani to host the Takumbeng. Otherwise, it is called the Takumbeng host.
Nfor	King

Ngang	Medicine
Nighoni	Illness, sick
Nighonishugar	Diabetes
Nighonifumbgwuang	Diabetes
Nsani	A successor A village plaza (major junction where rituals are performed
Nto'o	Fon's palace
Nzhinda	Successor/heir
Shugar	Sugar/Diabetes
Taa	Father
Tacheu	Lineage head
Takumbeng	Plays a more active (regulatory) role at some cults like pollution removal, purification, and fertility rites.
Pidgin English/General use	
Aki	Local gin
Afofo	Local gin
Compound	A unit of space on which a is lineage Settlement.
Coki beans	Beans paste prepared with palm oil and other ingredients.
Condry	Boiled bananas with groundnuts paste and meat.
Country fashion	Traditional ritual
Country pot	Clay pot
Evur	Witchcraft
Fufu corn	Corn paste prepared with corn flour and eaten with hucklebury
Herbalist	A traditional healer who treats illnesses using herbs only
Mamiwater	A ghost/shade believed to live in oceans, seas, rivers, lakes said to be mother of evils
Marabout	Haussa word for traditional healer with divinition powers
Medicine man	Traditional healer
Musong	Illness with multiple signs and symptoms, a Bassa word that has been incorporated into Pidgin lexicon
Native doctor	Traditional healer
Ngambeman	Traditional healer
Nyoungo	A cult believed to be a place where people die and go to work for masters; some form of invisible slavery
Pwem	Boiled cassava leaves cooked with groundnut without salt and eaten with cassava or plantains.
Puf puf	Fried duffs
Seer	Diviner
French	
Geurisseur traditionnelle	Traditional healer
Le diabète	Diabetes
Odontol	Locally brewed gin, otherwise called Ha
Sorcélrie	Witchcraft
Tradi-praticien	Traditional healer
Voyant	Diviner

Appendices

Appendix 1

List of main participants

Appendix 1a

List of main participants in Biyem-Assi, Yaounde

Name of participant	Age	Description	Province of origin	IDI	FGD	Visits/	Conversations
Biyem-Assi – Yaounde							
Martin	82	Retired diplomat	South West	1	1	2/3 weekly	Several
Maureen	48	Teacher	Centre	1		2/3 weekly	Several
Atangana	34	Unemplyed	Centre			1 weekly	Several
Jean Pièrre	58	Trader	West			2 weekly	Several
Chrysantus	40	Engineer	North West	1	1	2 weekly	Several
Stephen	52	Policeman	North West			2 weekly	Several
Regine	47	Researcher	Littoral	1	1	2/3 weekly	Several
Siani	52	Teacher	West			2 weekly	Several
Ze Nkoe	75	Retired teacher	South	1	1	2/3 weekly	Several
Clinic staff							
Nurse (Clinic 1)	34	Consultant	North West	1	1	20	Several
Nurse (Clinic 1)	48	Health of facility/Consultant	North West	1	1	20	Several
Nurse-Interpreter (Clinic 1)	39	Interpreter	West	1	1	20	5
Chief Nurse (Clinic 2)	46	Consultant	South	1	1	10	Several
Nurse (clinic 2)	40	Consultant	Littoral	1	1	10	Several
Traditional Healers							
Dr Tita	50	Traditional healers	North West	1		Several	Several
Dr Richard	55	Traditional healers	West	1	1	Several	Several
Dr Kabjob	64	Traditional healers	Littoral	1		Several	Several
Dr Ayissi		Traditional healers	Centre	1		Several	Several
Dr Abdou	51	Traditional healers	Far North	1	1	Several	Several
Other regular informants							
Doctor	34	MD	West	0	0	Several	Several
Doctor	50	MD	West	0	0	Several	6
Atangana	40	Traditional ruler	Centre	0	0	Several	5
Zanga	83	Traditional ruler	Centre	0	0	Several	Several

Appendix 1b

List of main participants in Bafut

Name of participant	Age	Description	Province	IDI	FGD	Visits	Conversation
Patient							
Samuel	75	Retired teacher	North West			Several	Several
Peter		Retired teacher	North West	1	1	Daily	Several
Sammy	49	Retired banker	North West	1	1	Several	Several
Florence	58	Housewife	North West	1	1	Daily	Several
John	40	Retired Journalist	North West			Several	Several
Monica	52	Housewife/ Farmer	North West			Several	Several
Mary	47	Housewife/ Farmer	North West		1	Several	Several
Adolf	73	Retired nurse	North West			Daily	Several
Ambition	56	Photographer	North West		1	Several	Several
Helen	68	Housewife	North West		1	Daily	Several
Clinic staff							
Doctor 1 (Clinic 1)	40	Medical doctor	West	1			Several
Doctor 2 (Clinic 1)	37	Medical doctor	West	1			Several
Nurse 1 (Clinic 1)	40	Nurse	North West	1	1		Several
Nurse 2 (Clinic 1)	52	Nurse	North West	1	1		Several
Nurse 2 (Clinic 2)	48	Nurse	North West	1			Several
Nurse 1 (Clinic 2)	50	Nurse	North West		1		5
Traditional healers							
Dr Che Bobisco	58		North West	1		Several	Several
Dr Tumasang	70		North West			5	Several
Alhadji	42		North West	1		Daily	Several
Ngwa	75		North West	1		8	6
Other main informants							
Fon of Bafut	58	King/Ruler of Bafut	North West	1		11	7
Queen Christina	40	Fon's wife	North West			8	5
Achirimbi Abraham (Muntoh)	54	Bafut Prince	North West			Daily	Several
Ana Ayongwa	70	Housewife	North West		1	Daily	Several
Matthew Mbolifor	68	Family head	North West	1	1	Daily	Several
Taa Mboo	40	Nchinda/Palace Aid	North West			Daily	Several
Thomas Laburu	76	Family head	North West	1	1	Daily	Several

Appendix 2

Time table of fieldwork

Appendix 2a

Time table of fieldwork in Yaounde

	2001									2002			2003	
Activity														
	June	July	August	September	October	November	December	January	February	March	April	May	May	June
Clearance from the Ministry of Health/Ethical committee	***													
Contact local authorities	***													
Clinic visits	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Home visits		***	***	***	***	***	***	***	***	***	***	***	***	
Interviews					***	***	***			***				
Focus group discussions					***	***	***							
Community interactions	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Data transcription	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Data anaylsis	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Literature review	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Return to Yaounde for additional fieldwork													***	**

Appendix 2b Time table of fieldwork in Bafut

Activity	2002								2003				
	May	June	July	August	September	October	November	December	January	February	March	April	May
Contacts with local authorities	***												
Clinic visits	***	***	***	***	***	***	***	***	***	***	***	***	
Home visits	***	***	***	***	***	***	***	***	***	***	***	***	
Interviews						***			***		***		
Focus group discussions							***						
Community interactions	***	***	***	***	***	***	***	***	***				
Data transcription	***	***	***	***	***	***	***	***	***	***	***	***	
Data anaylses	***	***	***	***	***	***	***	***	***	***	***	***	***
Literature review	***	***	***	***	***	***	***	***	***	***	***	***	
									***	***	***	***	
Return to Yaounde for additional fieldwork													***

Appendix 3:

List of tools

Place and tool	Frequency/number
Biyem-Assi	
Observations	Daily
Conversations	Daily
Focus group discussions	8
In-depth interviews	18
Home visits	Daily
Attendance at clinics	Several
Community interaction	Daily
Bafut	
Observations	Daily
Conversations	Daily
Focus group discussions	8
In-depth interviews	18
Home visits	Daily
Attendance at clinics	Several
Community interaction	Daily

Appendix 4:

Sample of some tools

In-depth interview (IDI)/Focus Group Discussion (FGD) guide for diabetes patients
How was your life before you came to realise that you had diabetes?
When were you diagnosed? Can you please recall what the doctor told you?
What do you think caused you to develop diabetes?
How much did it cost you to diagnose and where was that done?
Can you explain exactly the kind of treatment that was given you? Probe - Which treatment have your ever taken and are taking now?
Which other treatment do you think you can take for the treatment?
What will happen if you did not have money to acquire your drugs?
When was the last time you treated yourself? When you go to the clinics to consult, do they treat you properly?
Since you had diabetes what has worked well in your life? Have you tried traditional medicine? Probe if divination is not mentioned.
Which do you prefer: the treatment that the native doctor proposed and the one that you receive in the hospital? Have you ever tried any other thing?
Have you bought medicines by yourself and used?
If you had more money do you think you could handle this your illness more than what has been done to you?
Does this diabetes affect your ability to perform your daily activities? Ask about complications.
What role does your family play?
What is your relationship with other patients, the community, traditional healers and health personnel here?
Is there some other thing you will like to tell me about your life experience since you had this disease? What do you think you can do to help yourself get better treatment?

In-depth interview (IDI)/Focus Group Discussion (FGD) for family member of diabetes patients
What are the diseases that frequently affect people here?
How was your parent/spouse's life before he/she was diagnosed to have diabetes?
When was your family member diagnosed? Can you please recall what the doctor him/what he said the doctor told him?
What do you think caused your family member to develop diabetes?
Can you explain exactly the kind of treatment that he/she has been taking? Probe - Which treatment they have ever taken and are taking now? Which other treatment do you think you he/she can take for the treatment?
What will happen if you did not have money help him/her to acquire your drugs?
When was the last time you helped your family member to treat him/herself? Do you accompany them to the clinic to listen to consultations?
Has the treatment in the hospital worked well? Probe: Have you tried traditional medicine? Which do you prefer: the treatment that the native doctor proposes and the one at the hospital? Have you ever tried any other thing? Have you suggested other treatments to him/her?
If you had more money do you think you could handle this illness more than what has

been done?
Does this diabetes affect their ability to perform daily activities? Ask about complications.
What role do you actually play as a family?
What is your relationship with other patients, the community, traditional healers and health personnel here?
Is there some other thing you will like to tell me about your life experience with him/her since they had this disease? What do you think you can do to help him/her get better treatment?

IDI/FGD with traditional healers
For long have you been practising traditional medicine?
How many patients do you receive per month?
What kinds of diseases do you treat?
Is diabetes common among your patients?
What are the local names for diabetes?
What actually causes diabetes?
Can diabetes lead to other complications, if not well managed?
How do you diagnose somebody with diabetes?
What do you check in your diagnosis?
After you have found that somebody is diabetic how do you treat him/her? Do you manage or you treat "CURE"?
What do you think about the treatment of diabetes? *Probe to know if it be cured or it is management of symptoms.*
How often do diabetic patients come for follow up?
Do you keep patient records?
What can you say about the treatment that you offer to patients with diabetes?
As a traditional healer how do you perceive hospital management of diabetes?
What makes traditional medicine more convenient to people?
What role do family/community members of diabetes patients play when they need your help
What can you say as your concluding statements?

Interview/FGD/conversation guide for clinic staff - carer of diabetes patients
For how long have you been working?
Within that time did you come across diabetes patients?
What is your view of the diabetes clinic that you run?
What is the magnitude of the diabetes?
What is your assessment of the number of patients?
What do you think is the cause?
What do you think is the cause?
Are there behavioural patterns that cause diabetes?
Is there much awareness in families about diabetes?
How do you help your patients with diabetes? How do you tell them about the disease?
What are the characteristics of your easy patient?
What is the characteristic of a bad patient?
What are the challenges and frustrations in caring for patients of diabetes? Do you find treating people with diabetes rewarding?
What is the role of the family?

Do you find your patients willing to take the advice you give to them? Is it common for people to stop taking drugs? Why?
How do you assess people's accepting their conditions? Do people have difficulty understanding the difference between cure and management? Why? Do you manage or you treat "CURE"?
Do you think diabetes causes much suffering to patients and their family?
What are your experiences as a medical practitioner?
What has been your experience with traditional doctors?
What else do you want us to discuss according to your experience?
Your last words.

Appendix 5

Samples of transcripts

Appendix 5a

Field notes at Etoug-Ebe Health Centre clinic 21/02/02

At 5am I went out of bed moved out to the main highway to hire a taxi to Etoug-Ebe. By 5.30 am I was there. Patients start arriving. 6am laboratory health staff open and start receiving patients and testing their blood glucose. 7am consulting nurses started receiving diabetes patients and consulting them. There are 85 patients on the list during this session. I sat in to watch what Nurse 1 was doing. She opens the consultation records of the patients, reads the FBS and BP then prescribes. If good outcome, she congratulates, if bad she blames. No patients spend more than 5 minutes. By 8.30am one of the consultants – Nurse 1 alights from her consultation room. Every patient is seated in the waiting room ready for health talks to be delivered. The group seems to be well organised today and all the old members know each other. I took my own seat at the back where I could see everyone.

Health talks

The health talks started at 8.30am. Three people are active in the exercise: Nurse 1 (female), Nurse 2 (male) and Nurse 3 (Translator - female). Nurses 1 and 2 speak in pidgin and Nurse 3 translates into French. Nurse 1 starts up: There were 70 patients attending. Nurse 1 introduced the session and later handed to Nurse 2. She greeted the group. The patients were advised to always "pay attention to health talks". To always sacrifice and attend because health talks were very important. This day and time that you come here are very important in your life. If you have an important activity it is good to go there while you are healthy. I pity those who hurry because they do not cater for their health. I am not obliged to keep your cards but we had agreed that we should always stay together. The important thing is that you should think about your health. We have to work together.

The education starts:
'Good morning. We are glad to be together today. Our talk today will be on insulin.'
She asked a question, "When you are on insulin which signs (side effects) do you expect? When you take insulin and there is excess in your blood how do you know? Eh Mami Francisca? I want Mami to help in answering this question. I took about an hour in the last two clinics to talk to her. When many people go into a comma they are transported to the hospital. That can be it but you will not know.'

Mama Francisca does not react, so another patient called Papa Jean takes the floor and gives his experience, "I begin to sweat and become weak. Once I eat a banana everything becomes normal.

Nurse 1 reacted, "If I have asked Papa Jean to talk it is because he is old in it. Any person who does not know how to take his insulin it means that we waste time here. . We have that magazine there for you to read. Some people have taken them home and do not read it. You have to know how it works. If you don't do it like that about 2-3 times you will think that your medicine does not work. You will think that you are epileptic whereas you are not. Then you will be running here. It times you meet your friends and they tell you wrong things. When you come here you start telling us that you think that it is this or that thing whereas we know what is wrong with you". She pauses as there was some confusion and lots of noise as more patients who were outside entered the hall and needed space.

Space was created for the new arrivals for health talks. She continued, "When I talk about insulin it is to help you know how to care for yourself. When you are on insulin, you can be told to take 10u a day. Its enough to keep you normal. If you never ate nor drank something the previous evening and in the morning you take it, you will become dizzy, tremble and sweat. If you are careless, you will collapse. You may think that it takes long but this can occur in 3 minutes. That is why such a person must always move with sugar, banana or biscuits. Those who are on insulin must be careful. The way they take it. Wash the place before you inject. For those on tablets, when you take less your sugar level will be high. When this happens the first effect is frequent urination, numbness, blurred vision. You will spend more hours at sleep and think that you are sleeping well whereas it is sick. Those with problems with their eyes know that the blood pressure of your eyes becomes high. How many of you have conversed with Musa today? Have you asked where it is? If you have numbness, boil water and soak your feet inside".
As she was delivering the lecture everyone was silent. Patients of other diseases and those who came with to escort diabetes patients gathered round to listen. She suddenly stopped and then continued, "I have talked much. I want questions now".

People became relaxed and shuffled on their seats. I patients indicated to talk and she asked him to do so, "Yes Papa ask your question.'
Patient - Regine: "You give us medicines to take for a month but at times they get finished".

Nurse 1 replied, "When it happens it means that there was a mistake. Excuse me. At times a wrong quantity is given to you. When the medicine gets finished please just come back. A human being is difficult. There are some people who have received more but they don't talk (tell us).

Another patient Pièrre - attending the clinic for the first time said, "This is my first day to this clinic".
Then Nurse 1 replied, "How did you find yourself here? When a friend invites you to this clinic it is good that you come here before this day. How many people have come here for the first time?"
Two people indicate with the show of their hands. There was a 1-minute pause as she turned and whispered to Nurse 2. Then a patient asked, "When you take insulin when are you supposed to eat?"

Nurse 1 replied, "It is good to eat immediately you take it. For glucophage we tell them to take during the main meals. For Daonil and Glibenclamide it's good that they take in the morning and evening. For the past two to three months we have not talked about care of your feet. When you feel that numbness it means you have a foot problem and have to check that every time". She stopped and announced the next day of the clinic. "The next clinic is on 21 November 2001.

Another patient stood up and asked, "I want to know if a diabetes patient can be pregnant?"
Nurse 1 replied, "Yes but you only take insulin. There are people who were on insulin and it has happened that it activates the natural one.

Another patient asked, "What about insomnia?"

Nurse 1 replied, "It happens when your BP is high or when you have a problem that is disturbing you.'

Another patients rose and asked, "What quantity of sugar is one supposed to take?" Lydia replied, "When you take that one it is to give you strength to look for food".

Another asked, "If your sugar level is high how will you know and what should you do?" Nurse 1 reproached, "We have just said this. Someone should answer."

A patient stood up and answered, "You should go to the hospital especially when you don't more have drugs.

Nurse 1 added, "You have read in the book that it is when it increases to 400u you will collapse and die but people stay like that with it for a week. You adjust your dose of drugs to 2 morning 2 evening. You we shall do the 1 to 1 discussion you will understand better".

Lydia rounded up the health talks and called on the President of the Diabetes Association to make an announcement. The president announced that there will be an executive meeting and encouraged people to volunteer to attend. At the end of the announcement the staff started calling the patients one after the other to collect their notes books and go to the pharmacy for drugs. Others who had not yet consulted went into the consultation rooms and re-emerged a few minutes after.

Appendix 5b

Field notes on my first day of contacts in Bafut

When I arrived this morning on Monday 13 May 2002, I first visited the District Hospital to contact the District Medical Officer, Dr Dongmo Sylvester, and inform him that I have come to stay for a year and do fieldwork for my PhD. I took time-off to explain to him my topic and how I was going to go about it. I had earlier contacted Dr Piebeng who was acting in his place when he was away to Cotonou in Benin. He was ok and offered to lodge me. I quickly told him that I had a home already. When I went to Bafut to book for a home he was studying for a MPH in the Republic of Benin. I told him that I would like to see the Fon of Bafut. He replied that there was no problem with that. He advised me to book for an appointment else it will take some time. Later he offered to take to the Fon since he will not need an appointment. On the other side of the building was the secretariat. Mr Achirimbi Abraham (Muntoh – a prince of the Bafut Palace), the secretary, was sitting and working on a computer. He called for him and asked if the Fon was around. He affirmed. Dr Dongmo expressed the need to see the Fon and he replied that it was possible but that should only be after 10am. He then became busy.

Mr Achirimbi decided to take me to the Fon. We went through to Nsani, a small Market square with a ramshackle and broken round about. Here you have stores, off-licences, hairdressing saloons, and make-shift eating houses with mainly "Achu" (the main local menu) and water fufu (made from cassava) being sold. There were also lots of bars selling palmwine. In some of them both plamwine and industrially brewed beer were sold. Women were selling varieties of foodstuff in the open-air. Adjacent to the women was a hut where butchers were selling beef and pork. Directly behind them was a small patch of forest with only one tree and some shrubs. It looked like a fetish. We went pass them, then to the palace. We arrived the entrance where a gate was being constructed, moved into the outer courtyard where a hut hosting a talking drum was on a raised platform. There were a few trees and two granite stone pillars at a an interval of about 40metres. Far at the other end were three stones. The road moved right across to a quarter called Mankaha. At that far end and directly behind the Palace was a forest. This forest resembled an evil forest, which is always found in Grassfield palaces. When I looked to my left I saw the rest house where Gerald Durell was staying and kept his animals. All was beautiful around. Trees were blooming and everything around the palace green. The palace wall was earth redish with some bricks falling off. To the right a grandstand was being constructed. There standing was the Fon. Achrinmbi told me, "That is good. The Fon is out here so it will be easy for us to see him. I had met the Fon and chatted with him in 1999, so this was the second time that I was meeting him directly. We moved towards the grandstand and met him. Three young men were doing the construction work and four elderly men accompanying the Fon. One of them looked like he was answering querries from the Fon. The Fon stepped forward and met us. I bowed and Mr Achirimbi, who is a prince himself, greeted him. "Mbee".
The Fon replied, "Ngano, you are not at work now? What is bringing you to the palace now? He moved closer to the Fon before answering.
"Mbee, this is Dr Awah. He works on NCD projects and will want to see you and talk with you".
The Fon stared at me on the face as if he was going to make me out. "You look familiar. Isn't it?," he asked. I replied, "Mbee. I met you here in the palace in 1999 and we spent

some 20 minutes together". Things were going to work as Muntoh told me. The Fon was ready to receive us immediately.
"I see". He replied. He turned to Ngano and said, "Go through the other way and I will meet you in the hall behind the secretariat. He went as if he was leaving the palace and entered a small door at the entrance at the far end of the palace. Some two elderly men were standing at that gate. We moved through a brickwall into the entrance where there were 10 houses. There were the Fon's wives and children displaying works of art. We greeted them and continued into a second entrance where there was an open field with trees blooming. From here you could have a full view of the rest house. We turned right into another gate, then into another gate where we saw a secretariat belonging to the Fon. There was a photocopying machine and a computer there. A shelf and a cupboard with some files. Ngano moved forward to him and told him that we have come to see the Fon. At every stage of our movement, Ngano stopped to explain to me what a symbol or a position in the palace meant. Then we reached the Fon's secretariat. He introduced me to two young men and told them that we had already met with the Fon and he has asked us to come to the secretariat and wait for him. One of them moved through the back door and re-emerged some minutes afterwards. He told us, "Wanna pass so enter for that hall". We followed his instructions. The hall was quite big and had a raised stand where the Fon sits and looks down at people. "This was not where he received us in 1999", I told myself. He opened a door and appeared in the hall. We stood in respect. He took his sit and we followed.
"Eh-he", he started. "What can I do for you?" he continued.
Ngano replied, "Mbee, this is Dr Awah. He has come from Yaounde. He works with Dr Mbanya in the NCD programme. He has come to greet you and to tell you that he is around. He is better placed to inform you about his programme".
I stepped in, "Mbee. I am Awah Paschal, a social scientist. I work with Dr Mbanya on the NCD programme. In addition, I am a student with the University of Newcastle in England. I shall be staying in Bafut for a year to study how people try to cope with diabetes within their family setting and in the entire Bafut community. Once in a while I will visit the palace to see how things work here".
As I spoke, the Fon nodded his head. He looked at me and asked, "You say your name is Awah?"
"Mbee", I replied.
"Good". He said and continued, "You come from where?"
I replied, "From Kom".
"I see. And you bear Awah. Have you checked around to see if you don't have a family in Bafut? That name is Ngemba so might be Bafut. You are welcome to Bafut. You have been here so it should not be very strange to you. We shall be available for you to consult at anytime. Make sure that you inform me whenever you need me. I will always help". I answered all what he was saying with "Mbee, Mbee". You don't say "Yes" to a Fon. He turned to Ngano and asked, "Where is Dr Dongmo?"
Ngano replied, "He is in the office. I left him there before coming here". The Fon reacted, "I have stayed for long without seeing him so I thought he has travelled. How is the hospital? Is everything well there?
"Mbee", Ngano replied.
The Fon nodded and asked me, "Have you ever been shown the palace?"
"No", I replied.
"But you will like to know?"
"Mbee", I affirmed.
He stood up and told me, "Go that way with Ngano and we will meet in the inner court".

We left the secretariat, moved out to another courtyard, then into a gate with two pictures of a lion. It was like passing throught a room. We moved into a another inner court. There were some stone stools there and a few chairs. Then we moved into a room. Ngano turned to me and said, "This is where the Fon sits and settles disputes. When you are coming with a dispute you will just come and sit here. If you are somebody that has been initiated to talk to the Fon you will tell him your problem; if not you will use an intermediary. Even so that is not enough. There are always some of the members of the traditional council who will eat here and eat there. They will call for the person who has a palaver with you and ask for something and then call you and asked for something. They have eaten on two sides. These people will keep on turning you round and round and always tell you that the Fon is not ready to hear your case now. By the time you see the Fon you would have lost a lot. So it is here that the traditional council sits. We entered into another room to the left of where were standing. Ngano remove his cap and kept on a counter. "Nobody is allowed to cross this gate with a cap on his head. All caps are kept here". We jumped down a two stairs and then into a larger courtyard. I recollected, "This is where the Fon received us in 1999". I recognised the hall. OK I see. The Fon suddenly appeared from another end. There was a building that I did not notice in 1999. It is a tall grass-roofed wooden building with pillars of dead palms and carved pillars of wood. There are a lot of traditional artefacts displayed in front. The house looked old and I began to wonder what the house was for. In most Grassfield Kingdoms, the houses where the Fons sleep are not roofed with zinc. They are always roofed with grass. It is also believed that the missing Fons stay in such building. "The building is very gigantic. I have never seen this before". I told myself. The Fon called, "Come this way". We followed. He had used another door to come out to meet us. He started introducing us to the building.

"This building you see like this the heart of Bafut. If this building is destroyed then we are finished. It is called *Achum*. This is where all our ancestors live. They come and live here when they disappear so we pay particular attention to this house. It is one of the shrines of this kingdom. Our tradition has ancestral workship. That is, the Fons of Bafut pass away, they disappear but they remain in this shrine in the form of spirits and therefore we invoke them in here and we can do quite a lot of things with spirits of the late Fons of Bafut here. So it is a very powerful shrine.

The conversation continued, "You mean that you hear them when they talk?

"We hear. Why not? We discuss. We talk to them, they speak to us, we communicate with them".

"And what do you call this?"

"Ancestral worship. Yah that is it, that is in fact our traditional religion. We belief in it. We belief in life after death. That is why this shrine is very important for us".

"But Mbee, you are a Christian as I know?"

"Infact I was first born in this ancestral traditional religion before I went to school here in Manji and in Bali. They baptised me there. What you have to understand is that there is a lot of similarity between traditional ancestral religion and Christianity. The differences that you have are procedural. I mean the processes of worship. If not everything is the same. The Ten Commandments in Christianity are applicable to us too. If you go out there in the outer court you will see two stones on which we used to punish people who committed adultery. The stones are still there. Then you must always worship these ancestors here. If you don't appease them they will break loose and trouble will come to this land. If you are a Bafutman you must belief like that. We know that we have our ancestors to whom we must give sacrifices. Christians and non-Christians live here side by side. We tolerate religion that will respect the laws of our land. Inside this house fire

burns throughout. There is no time that fire goes out. On every "Country Sunday" the people of Bafut come with firewood and offer to the palace to make sure that there is continuous fire. This shows how important this house is. Try to come here on a country Sunday you will see what is happening. They respect their tradition. You cannot deceive a Bafutman to go against it. I think that Ngano has shown you where the traditional council judges cases. On a Moumeta-ah I also initiate Bafut people into some of the traditions of this land. There are many things that we do here so everyday we are on the move. I don't spend "Country Sunday" out of Bafut. I make sure that I am always there to settle disputes here and there. Perform this or that traditional rite, put this or that successor."
"Can one enter this house?" I asked.
Ngano exclaimed, "No-No. Not at all. Entry into this house is very restrictive. Princes and princesses enter this house once in a year. Not everybody enters there. It is not possible. There are special people who enter to offer sacrifices. Even so, it is not everywhere that everyone can pass. There are places that are restricted to us. There are some of those old people who hold this land that can enter everywhere". The Fon listened keenly and smiled, then turned to me and said I have to meet a group of people who are coming from Yaounde to see me. I will leave you. "Ngano, show him around and we will meet later". The Fon disappeared into a door and I continued with Ngano.
"Here is the residence of the Fon. This is where he sleeps. You are not allowed to climb those steps so don't move that way. He usually sits here and initiate people who want to have the freedom to talk to the Fon". Ngano pointed to a spot under a plum tree. "You know this hall now?" He asked and I nodded in affirmation. "Here is where he receives visitors", he explained. It is in here. He sits on that chair."

We did not stay long again. Ngano had introduced many of the places on our arrival. We returned to Nsani and had some launch. After that we went to the hospital. I did not stay long there. I had just got the house and was struggling to settle so I returned home. When work closed, Joe stopped by to greet me and know my programme. I told him that it was necessary for us to establish a list of diabetes patients that we will visit. He told me that it was possible for us to do so the next day. Joe's clinic had dwindled and many of patients were not more respecting appointments for control. Their excuse was that there were no drugs and again no strips for the control. I got up very early in the morning and discovered that many people were well dressed. It was not Sunday", I told myself. I asked Mr Suh, "Why are many people were moving from Manji towards Nsani? Why are they carrying many jugs of palmwine and food that way too?" Mr Suh replied, "Today is Moumetaah, the Bafut country Sunday. Here in Bafut we have eight days in a week and in those eight days there is a day that we rest". He was telling me what is characteristic of all Grassfield kingdoms. He moved into his house and emerged with a book. On it were written "The Bafut Calendar" and a phrase in Bafut. He opened it and showed me explaining each day to me. There was the Market day too mention in it. He explained, "On a Moumetah, the Fon receives people in the Palace from morning till evening. Those who have cases go and see him and he judges them with the traditional council. Those who have successors to install do so on that day. If a successor is not presented to the Fon, he will never recognise you. You cannot even stand somewhere and say that you are a successor. No one here will listen to you. That is the time that you as a successor are also initiated to talk to the Fon, if not you will never be able to present a problem to him. So on a Moumetaah like this, you go can go to the palace and sit there and see all those things. This is also the day that quarter go and give food and firewood to the Fon. This usually in the evening when everything has finished and he will come out and listen to

your problems and talk with everybody. People will dance and he will feed them at the end. There is always much to eat there. After this chat with Mr Kevin, I returned to my home and dressed up, then went to the hospital to find out a few things from Muntoh. At 1pm Muntoh told me that he was going to the palace for a meeting of princes (Chong). We both left together and I stopped at my home. "No company at all", I told myself. Everything was new to me. My only friend around was Joe whome the Dr had introduced to me to act as my guide to many places. "How was I going to go to the Palace in the evening" I asked myself. I decided to go to Nsani at 4pm and distract myself over a drink. When I arrived I stopped at Ndalaah but found that it was full with very young boys and girls. I left and went across to Mami Pau where there were many people. People were drinking heavily. You could see a person with 2, 3, 4 bottles of beer in front of him. There was a lot of merry making. Some people emerged from the road to the Palace in traditional regalia. I pinched one man at my corner and asked, "Who are those people?" He replied, "Those people are coming from the palace. They were there since morning judging cases. That old man you see like that, that Pa is the oldest living son of Achirimbi. He is terrible. We call him Justice. That mans like sets a lot of confusion. He eats here and eats there. He has lost many of his children just because of his bad ways. The ancestors have punished him. When you have a problem and you take to the palace, he will eat from you and eat from that man with whom you have the problem. Finally he will not settle it. He cooks by himself. He can spend the whole day sitting here and drinking only listening to what people are saying. Then he only intervene to cause confusion or tell you that you have offended the Ngumba and you have to pay a fine. As he was saying Justice and other princes moved in. Some young men who sitting on the benches nearest to the door gave way and they sat. I thought that was at their request but during my stay in Bafut I was made to understand that those seats are always reserved for princes and princes.

At 8 pm I retired home to sleep.

Appendix 5c

Conversation with Dr John Che (Bobisco) – Traditional healer in Bafut

Name:	Dr John Che (Bobisco)
Age:	52 years
Sex:	Male
Marital status:	Married
Occupation:	Traditional healer
Place:	Bafut
Date:	22/11/2002
Time:	3.30-5.35pm

Q: Do you know some diseases, which are chronic, that is, which have reached some standard and are very difficult to treat, which if somebody stays with them he will die?
A: Yes, you see something like Asthma, something like abdominal pains
Q: Under belly (lower abdominal pain)?
A: Yes, things like this easily kill, i.e. AIDS I have been beaten with.
Q: Which other chronic diseases are difficult to be treated? That is, which you treat they go and come back; you take a long time to treat them; that if you stay with it you will die?
A: For us we treat all. There are medicines which I give, the ones which I go and they give me, or you come and give me your complains, and then I go and complain to them that this is the case and then they say "yes"
Q: You go and complain to whom? Who give you medicine?
A: The businessmen.
Q: Like who, who?
A: The person might belong to us. Some people are taken to the bush and they stay there, they cannot tell you witchcraft, they stay there to show herbs, they show us these leaves which can cure this sick, and they are not taken like other people who take things from others.
Q: So when you somebody with a disease what do you do? When you see somebody with a disease?
A: When one comes and complains, let's say about the pains as I told you about the asthma and the 'pensas'. I will touch it; then we have her under weight and then we tell her go and see the medical, and if he doesn't agree he should show him some other way.
Q: Now I want you to name me all those diseases that are difficult to treat.
A: They are many. You know of the kidneys; that if your kidneys are no longer working you cannot do anything. You are not acting?
Q: You don't act?
A: You don't act.
Q: Like how?
A: Sexual intercourse. So I have medicine to this sick.
Q: You have which other sick?
A: Me, I have like back pain, broken legs, when you have an accident, I have to carry the legs for sometime and cure it.
Q: Name the ones that pose you a problem to treat.
A: There is no one that I have not succeeded to treat.
Q: You have been naming quite a good number of them.
A: I have my record book; you can see it from there, the type of patients that I have been treating

Q: OK. You treat your patients and register them.
A: Yes, I register them.
Q: I want to know from you. We will look at the book after
OBS. He insists and I collect and have a glance at it and keep with me.
A: Malaria, back pains, abdominal pains, broken legs and diarrhea
Q: What again?
A: Protection
Q: So you protect people?
A: Yes.
Q: Against what?
A: Against all these small diseases like now, there are so many cases like: protection against power or against somebody; or protection only or against asthmas and abdominal pains.
Q: What of diabetes patients?
A: Diabetic patients I use to receive them?
Q: Now I did not hear you talk of diabetes as chronic disease, I didn't hear you mention it, are they chronic diseases?
A: They are chronic.
Q: Are they difficult to treat?
A: They are not strong in treating.
Q: OK. So it is easy for you to treat.
A: They are easy for us to treat.
Q: I want to know from you Dr, you have talked about patients, and you also treat patients of diabetes, not so?
A: Yes.
Q: What do you think causes diabetes?
A: But I cannot know the causes of sick except through divination. When you go and throw those things then you know what has actually happened with the patient.
Q: Especially when you go and throw, how do you know, they tell you that what has happened?
A: We have not gone into that.
Q: Have you ever thrown and they will tell you that it has given you a cough.
A: They only tell us that they fear it is hypertension, so go and get this type of leaf or bark of tree and that it will cure him.
Q: OK, they have never told you that somebody has thrown it on him.
A: Of course there are some people who are witches so they through these diseases on people. They can throw hypertension on you.
Q: So when you throw what do you know those witches?
A: Njoh, as we call it in the vernacular.
Q: When you throw those "njoh", do they tell you what or who has made the person to be sick?
A: "Njoh" tells you about the sick in a person and not about say "njoh" knows that person or that somebody is responsible because you might go and find trouble with the person. You see it and you know it.
Q: OK. Especially when you see it and they tell you that this or that one might have caused the problem.
A: They tell you that this man is having this, do like this and you treat him.

Q: What of those with diabetes.
A: I give the medicine when the patient comes, I go and touch him, I know what medicine to give, if the patient gets well then we will be happy.
Q: Yes, but when you are treating, you make him know what has made him have the sickness?

A: When I have done like that they give me the medicine to treat the patient. When you see the patient sweating, and rest in a while, you just know that the patient has it. I see the signs when the person is in front of me.
Q: Those other diseases like malaria and others; do they have the cause like diabetes?
A: The diseases are all common and so all come from one source.
Q: Which one is more severe? Which is more stronger: malaria, purge...?
A: Epilepsy is common amongst children whether it comes from the parents, one cannot tell.
Q: Do they have the same signs?
A: No, they have different signs. Somebody with malaria has yellow eyes.
Q: So what of somebody who has the other diseases?
A: A person who has asthma the eyes are frightful.
Q: You talked of asthma holding somebody's eyes, hypertension that can make somebody not to have erection. You also talked of other problems: if somebody has diabetes or hypertension, can he have the same problem?
A: Those are the same family. Somebody who has diabetes can also have hypertension. They are brothers. You can have one and later on you have the other.
Q: What of somebody with epilepsy?
A: It has its own sign; all these sickness has it own signs.
Q: OK. They have their own signs, which are those signs?
A: I touch a patient and I can be able to detect a particular disease like abdominal pains, and a series of other diseases whose names I cannot completely give here. When you touch a place where the sick is localised, the patient reacts by crying out like this "ah, ah".
OBS. His language doesn't seem to convey any message mostly understanding or bring out any salient point about signs.
Q: OK. You told me that you treat all those diseases and that the only one you have never had to treat is epilepsy.
A: Because I have never had the opportunity to receive one but if I have it I will go and complain that they (the spirits) should help me.
Q: Your other colleagues also cure it?
A: Well, there are natural doctors who have their own medicine. For this our own, it takes years, they have to take you to the forest for about some years.
Q: So you spent time in the forest?
A: Yes,
Q: For how many years.
A: For two years before coming back.
Q: And then when you came back?
A: I just started. So any thing which I want to do, I must consult them, if they say yes, OK, I go ahead.
Q: Now you consult them and they tell you to treat them, how do you treat: diabetes?
A: You know there are so many medicines, when you take this one and mix it up with this other one it will treat this sickness. Yes, and then you go and harvest it and come and grind or cook and tell them (the patients) how to use.
Q: Do you do that to different patients who have the same disease or they are all the same?
A. They are all the same.
Q: I also want to know about diabetes?
A: They usually kill.
Q: Why do they kill? When you can treat them?
A: When you have a disease and you don't go to the hospital. How will the doctor know that you are sick?
Q: So those who die from it die because they don't come for treatment?
A. They don't go to the hospital.
Q. And what do they come and buy?
A. We only treat those who have been here.
Q. Could those your people tell you that if this man is not treated he would die?

A. Yes they usually tell me. Not all people come and see them. If they come and go, it will be easy.
OBS. He is not very clear in talking about this issue.
Q. So as you were saying, can you completely treat diabetes?
A: If somebody does not have it you can see it.
Q: So these patients don't more come?
A: They do not more have it. Altogether I have only received 315 patients since 1994
Q: Now all these diseases we have been talking about, can anyone who has it deliver a child who has it?
A: Yes.
Q: You have hypertension and you deliver a child who has it?
A: Yes, even if you are having asthma, all your children will have it.
Q: Even diabetes, and all the other ones?
A: All of them. They are all inherited diseases?
Q: So can these conditions be caused by witchcraft? That is, can witchcraft make you to have all these things?
A: Any condition cannot count because all things come from eh...
Q: Come from where?
A: All sick comes but not from witchcraft.
Q: But are there some that can be caused by witchcraft?
A: Yes, some can be from witchcraft. For that I give this protection. Which means that if witches use to worry you at night, you come and call us and we come and do it.
Q: OK. I want to know from you, are there some other diseases, which are not serious as these ones but which are similar to them, though not really them? There are diseases which will look like which will look like diabetes, but which are not, are there some?
A: Yes, there may be some but not that some people do take care of them as they take care of the other ones. But because they do not really study what is actually done, because some people see that I have a patient here who is having diabetes, because they are like, like some ordinary persons-patients- which is not good. They seem to have taken ordinary medicine to cure asthma you are killing that patient. They just jump and begin to try. Either you know or you don't know. Don't just begin to try this or that medicine. If you don't know the sick, don't begin to try one medicine after the other, you are killing the patient
Q: But it is easy with those people who have power, who have power to try?
A: It's those who take their secrets from others.
Q: Have you been training people to learn your own secrets?
A: Of course I train my child. Some people are better trained than my own because they are gifted. I don't know what they go and do or you should give this or that before I give you medicine for asthma, I don't know, because I cure it.
Q: Don't you have the challenge to treat some people that come to you? That is compared to the other diseases. That is to say, you try to treat diabetes and high blood and you are unable?
A: No, I can never have it.
A: You can never?
A: I can never have it because I am sure with those who give me. They tell me "Take this, you treat this". Whether at times they will begin to disappoint me I don't know.
Q: Do you think that your family members have been helping you able to take care of the patients, for example your child?
A: Yes, like that one outside there, when there is too much work for me I tell him to help me this way. Help me do this.
Q: So he already knows many of the things?
A: Yes, he does.
Q: What role do you think the modern doctor in the hospital, plays, to take care of these patients?
A: I don't know because I am not on that their part.
Q: OK. But do you think that he has a good heart to treat the disease?

A: According to my own he plays a good part, meanwhile the other person can play his own part.
Q. Do you think that his own way of seeing the medicine, because of that thing which you throw like your own laboratory, does his own laboratory work like yours? Does it talk like yours?
A. I don't know. I refuse to say something concerning his because if I say something concerning his, he can also say something concerning me.
Q. No. We are exchanging views. What has he got in his laboratory, which you also have? Because yours tell you the truth and that is why a disease cannot challenge you. Do you think that that laboratory you have here can make you treat a disease that is more than you because you can have such a disease and consult the laboratory?
A. Yes of course.
Q. So how do you do it, or look at it? Which is better to be used; Your laboratory and that of the hospital?
A. I cannot say something concerning that.
Q. Why not?
A. No.
OBS. He deliberately hesitates to answer the question.
Q. I want to know if there is any difference between what a man needs and what a woman needs for treatment?
A. There is no difference.
Q. How do they respond to treatment? Who gets well sooner than the other?
A. There is no difference.
Q. How do the family members of these patients help to make them well?
A. You know for us native doctors, some people think that just taking the herbs from behind the house can give you the treatment. So they see no need of paying us when we do a good job for them. So if you go into these books you will see so many debts that people owe me. Some native doctors are gifted; some don't even give you good medicine. The ones that do not give good treatment are those who make us to be called quarks. Some can bring you, like one from Wum came here, I treated and there was no body to pass and collected him. He was just abandoned to me. Some family members behave very badly. Some help at least. They bring the patients and when we treat they come back to collect them.
Q. Now, when they bring the patients do they really feel that they will help the patients?
A. When you come to me I will ask you, who has sent you here? Do you agree that I will help you? If you agree I will say OK, let me go and ask and see your disease and come. Even if you go to the hospital you do not put in your mind that you will go there and they will treat you, you can go and come back without being treated. Before you go just have the belief. If you have the belief you can go and other people will treat you and you will get well. So let every patient have the belief that if I go there I will get well.
Q. I want to know among the following diseases: hypertension, asthma, diabetes and fainting fits which of them is more frequent?
A. If you go into my book here, out of 315 patients you will be counting like 200 patients with asthma and the rest can be divided into the other diseases.
Q. Which is the most serious?
A. AIDS is the most frequent disease here in Bafut and if you go to check, I only go out when I am called for AIDS. If you go to check, there are about 100 or so cases of AIDS that we have treated in this group since 1994.
Q. I want to know why is it that most people have asthma?
A. That one can be best known by you people because our people (spiritual guides) always tell us this patient is having this disease or that and you should do like this.
Q. They don't tell you why they have this or that disease?
A. No they don't tell us.
Q. Even if they don't tell you what is your feeling about it?
A. Well it may be that it is just a disease that comes from the body like that. Somebody may cause it. You know that people are jealous.

Q. Is that all?
A. Yes.
Q. You said that the treatment of high blood and diabetes are easy.
A. Yes.
Q. Which ones disturb you a bit?
A. Only death.
Q. Only death?
A. I treat all of them and only death can disturb.
Q. So none of them is above you?
A. There is none that has treated me badly. If you name has entered this book you certainly know that you will be well.
Q. Why is it so?
A. Eh, my people
OBS. He slows and stays quiet.
Q. Yes, your people. Please explain.
A. Yes, my people give me. They only know how the power works, if they give me I give the patients.
Q. I will like to come back to you. Are there other aspects or your experiences with patients that you will like to share with us? Or which you feel that we should know about it?
A. They are there. We often come together to share our views how to pray or care for the patients. Our main goal is to capture real people. So if you can go out and meet the real people, I think you will be known better and for us the native doctors we pray for the doctors.
Q. What experience have you acquired as a native doctor?
A. Well, I came out after being stolen and taken to the bush like that as a native doctor. Since there is no improvement with us I came out and the people were saying: this is like that this is like this. I did not know until when I came and they continued to tell me to work like this. Other doctors have just become what they are like that without passing through what some of us passed through. I could treat about 32 per year, but now I just sit like this. I had tried to leave but following the information that you sent to me I decided not to go to where I wanted. So I can sit here and still send word because the letter is still there. Even tomorrow I can send word because I have been contributing there since. I have been sharing medicine outside without going there.
Q. Do you doctors in Bafut, have an association where you sit and discuss your problems like this asthma, hypertension, diabetes and epilepsy that cause a lot of problems? I mean seeing how to tackle them.

A. That is a very good thing, for us. We do not come together again because of problems. The thing is that when I have a problem I go and consult my people. They will advice me to go to a real person who can have the same medicine like me.
Q. Why do you not really meet?
A. I don't know because it is ours. Those who take their medicine tend to be very expensive. There are many irregular practices amongst such people. That is what has separated us from being together.
Q. Do these people have their association?
A. They have their association and they price a lot. We are still planning to have ours, so that we can agree if we have to take 3000frs from asthma patients. I have been sending people outside like those who take. If I do not take 3000frs, they will go outside and take 30000frs. It is just that, just add a single 5frs on top of it, and they have been adding like that.
Q. Who tells you how much you have to price a patient?
A. When I have a problem I go to my people and on coming back, they give the signs, which you will have to use, that is they write your sickness with what you have to pay.
Q. So this 27000frs for 12 litres of medicine is your people who have told you?
A. Yes.
Q. If somebody comes to you to treat diabetes, how much do you charge him? What will you ask him to make sure that you cure him, since you are sure that you will cure him?

A. They are only the same signs that have been written.
Q. I don't know exactly what that patient tells you. I just want to know exactly what he has to pay.
A. The sequence is this: if you are a patient of abdominal pains you will bring 3 pounds of powder, 27000frs; 4 pounds of powder and 40000frs and 30000frs for medicine.
A. Some around 3000frs; some about a litre of oil.
Q. What again? They don't ask for fowl, goats, blankets?
A. Heh Heh, Heh
OBS. General laughter.
A. It depends on the sickness. When they ask for these things it is to use them to treat the patient.
Q. Do you have any other thing?
A. No.
* Thank you Dr John Che for coming to discuss with us.
A. Thank you also.

Appendix 5d

Focus group discussion (FGD) with patients of diabetes in Biyem-Assi - Yaounde

Place: Restaurant Belle Etoile
Date: 30/11/2001
Time : Start 4.15 pm end 6.00 pm
Moderator: Awah
Language: Mixture of English and French, then translated into English.

* Do you know any diseases you think are a problem today?
2. Diabetes
4. Malaria, AIDS, Asthma, Filaria
3. TB
1. Diabetes.
* Q. You have listed only infectious diseases. that is those caused by bacteria. You have not named CVDS but only diabetes.
4. HTN, Paralysis.
Heart attack.
* Q. I want us to talk mostly about CVDS, heart attack, stroke,diabetes,Hypertension etc. According to you, why are these diseases a serious problem today in our society? What is the impact of these diseases in our society?
4. I know they affect all age groups. It may be we lack hospitals for their treatment. We cannot find appropriate drugs in hospitals for their treatment.Some people stay away from hospitals b/c there are no roads.
* Q. OK we will just go round the table and each person will say which disease he is suffering from, when he started suffering from it, describe the evolution of the disease today and which hospitals he has visited.
4. Last year 2000, there was a general screening of diabetes in the central hospital. I went there and there was nothing and in the month of October, I went for a mission in Niamey Niger and in November, I had diabetes. It is very hot there as compare to this part of Yaounde Rural. I started drinking water on an irregular interval and urinating. I decided that I could consult. I went to one clinic at Niamey. They screened and saw that I had diabetes. My eyes were white. At the clinic, I was told to buy diamiclone and I bought and everything started to go down. I was examining it every week to see the progress of my illness. When I returned in December last year one friend told me that if I am suffering from diabetes, I should not go to the central hospital but I should go to Etoug-Ebe. I went there and at the moment, they are taking good care of me. Counselling is well and the drugs are very cheap.
3. The disease started in me since May but i discovered it on the 27th June . It started with a small fever and it was treated in the quarter as usual but on change was seen. I went to the village but saw no change. I went to the AD LUCEM hospital. It is there that they discovered that i was suffering from diabetes. I was sent to the central hospital and i fell into the hands of DR Mbanya. He prescribed me to take insulin, i took it through injection and my situation started improving. I spent ten days in the central hospital and was discharged and given some advises. In the quarter my blood sugar level was still high, I went back to the hospital and saw but Dr Feuzeu there was no change. One friend

advised me to go to Etoug-Ebe, they tested and saw my blood sugar level was still high, i was prescribed another drug with insulin, this i am taking up till now.
2. Mine was discovered in November 2000. I used to work very well in the farm so that when I worked I used to have muscle contraction. I used to drink about 20 litres of water a day and urinate about six times in an hour. I didn't know what was happening and somebody asked me to go to the hospital. So I went to Etoug-Ebe in November. I was now suffering seriously and I told them that I was suffering from diabetes. They told me that I have sugar in the urine and not in the blood. I came back and they told me i had diabetes.
1. Mine started in 1995. I had scholarship and went to Japan. There in Japan most of the food we eat there contain a lot of sugar. After some two months, I started feeling a lot of heat. Sometimes I noticed as if I was feeling cool but there was no cool. I went to one dispensary but the Japanese did not understand English. So I explained and they did not understand me. After six months, I started urinating allot. So I reduced two months to my stay in Japan. When I arrived in Douala, I was sweating. When I came to Yaounde, i went to Effoulan dispensary and the doctor consulted me and gave me antibiotics. One day I went to Etoug-Ebe, they discovered that I was suffering from diabetes. They gave me some drugs and I took those drugs and got better. When I was transferred to Nso. While in Nso, the thing dropped to about 90° because in Nso, we had a clinic and every 9th we pay 100 francs for test and we pay drugs. Again there was this Korup National Park Project. I was selected to go and work. Since it was field work, I was to do field trips and I thought that the sick was finished. I discovered again that the sugar level has gone up, so I went to the hospital at Mundemba, Dr Karbot gave me some drugs and it reduced. Each time I went to the bush and it was high, I took those drugs and it drops. When I came back to Yaounde, I registered with the diabetic centre of Cité Verte. But I left the place because when you get there, there is allot of long procedures. When you get there, they don't take your blood pressure immediately they don't give you drugs, they say come at 3 PM. So with that I felt discouraged and I went to Etoug-Ebe . There, we are orderly served and now I have been taking some drugs and sometimes it rises and falls depending on the type of food I have taken. But now I am struggling that it should be stable. Now, I am still at Etoug-Ebe taking the treatment.
* Q. I want to ask this question. What has been the impact of this disease on you and your neighbour?
1. The impact is that i have lost allot of friends with whom i used to stroll b/c they think that when we sit, we can chat, drink and eat and i will tell them that i am not used to any type of food. Some of them find it difficult to sit with you b/c they cannot forced you to drink alcohol. Most of them i always try to explain to them to know that i am a diabetic patient and also I have indicated to my family that i am a diabetic patient and they should also know that I have to eat at the right time and not any type of food. Our only problem now is that since we are still in active service, we cannot respect the time that we are been given to eat. This because sometimes you have to eat after three hours and when you are busy doing some work somewhere you will not eat and sometimes you can even go to look for food you will not see.
Another major problem is that the medicines which we are supposed to take are very expensive. You know with us you have allot of relatives and children under your care and if you are taking insulin and a bottle of insulin like monotard is very expensive at 6000 francs. It is very difficult you buy 3 bottles a month with the number of responsibilities, that is your family members and children that we have. These are some of the major problems we have.

4. Yes Mr Fonguh have said we loose friends and in the house my family knows that I have to eat from a special pot b/c I don't have to eat the same food like them b/c I am not supposed to eat some food items, so they have to eat at their own time b/c I can also eat on my own time. They can eat when I am not there and I can eat when I need to eat. In Yaounde here some people are lucky to have neighbours who are comprehensive but I have neighbours you cannot even say good morning to them and you don't even know their names. For neighbours when they are drinking I will take only soda and when they ask I say I have just taken drugs. They will understand.
3. At the level of my environment, I am trying to convince the neighbours to know that as they see me, I am suffering. I am also a bit disfavoured especially at the level of food I take. For example, when I am with my friends, they drink alcohol and I take soda. I have been taking coca cola for some time but it disturbs my health and I abandoned it. For food, all family members know that I am suffering, so they don't joke with food they want to give me.
* Q. Has your illness ever disturb your work?
3. No since I got this illness I stopped only for some time but now, i am working normally.
2. I am a hard worker, when I am at work , I work as I used to do.
1. I think that the illness has disturbed me b/c I was thinking to do my research but when i got it I had to stop; for example as a civil engineer, I am a field worker and I need to do some calculating reasoning. Since then I have never think of asking for a scholarship to travel out of the country.
4. The impact is that where you live and your people know that you are sick, they may not know what to cook for you and what to eat for themselves. You need to try yourself to look for things which will sustain you.
* Q. It seems you have talk mostly about diabetes. Lets talk on CVDS and how they manifest in you. That is symptoms.
1. You urinate allot always thirsty and always tired, always dizzy, don't see very well when it is hot.
* Q. What about the other diseases for example HTN? Do you know their signs and symptoms?
All of them said they don't know the symptoms of Hypertension, heart attack and stroke.
* Q. So we are talking only about diabetes. That you know only about this?
All said yes.
* Q. If you find somebody around you with symptoms of diabetes, what do you do?
4. You ask him or her to go and consult.
2. I saw one woman in a taxi, when we were discussing, she said she always feel very tired. I asked her when you feel tired do you drink allot of water? She accepts and said she used to urinate even ten times an hour. I told her to go and consult the doctor b/c I am also suffering from that disease too. I am sure she was suffering from diabetes.
* Q. So your main advice you gave her was to go and consult the doctor?
2. Yes.
Q. Do anybody have another opinion apart from consulting the doctor?
4. When you go and consult, you can be ask to do diabetic test.
* Q. Can't you ask them to go and see a traditional doctor?
A. Everybody refuses.
1. You have reminded me of an incident which I experienced. When I took those drugs when I was in Nso, the thing went down, i was told that there are some traditional medicines that can cure, then i went to Bamenda and bought some two litres of concoction for 10.000 francs took it for one and a half weeks and almost died and i throw

it away. Since then, I never had the anxiety to go to a traditional doctor. Since then I have also discovered that all those traditional medicines don't cure diabetes. The essential thing with diabetes is to control and take drugs.
Q. do you have the same point of view?
1. Yes. At Etoug-Ebe, one patient indicated to me to come and take some traditional medicines in her house. He told me this medicine calms the diabetes. I went and took and i am taking it now I don't know whether it works b/c i have not yet gone for test.
* Q. Have you abandoned the other drugs?
3.No i have not.
* Q. When you mixed the two how do you feel?
3. Since she told me to take the two.
4. For me I think traditional doctors can't treat this disease b/c it is a complicated issue. They don't have instruments and they don't know exactly the herbs which can cure it. They beat about the bushes b/c when you are sick with the headache, they give you the same drug and when you are sick with diabetes, they give you the same drug. So they have not yet discover the herbs that can cure diabetes for now. So there is no need going to them for treatment.
* Q. All of you are following treatment in the hospital. What is your opinion about the facilities in the hospital? Do you think that the facilities are adequate? Are the nurses who take care of you well trained?
4. For the moment I cannot quarrel with them, for me I think that they are well trained b/c they advice us and they used medical knowledge to teach us. That is scientific which can be proved. They used the lab instruments. So I have nothing to disagree with them. At Etoug-Ebe, we are well treated b/c they give us advice. We have hours that we discussed and they give us complications which can come from diseases like blindness, muscle bones etc.
* Q. Do anybody have a contrary opinion?
1. I think diabetic patients especially in Cameroon are not well cared for. B/c the government would have taken care of these long-term diseases by reducing the prices of drugs b/c drugs are very expensive. Since we live on these medicaments and you have to take it throughout your life, and the poverty that is there, we are not able to pay them. Sometimes they prescribe that we should take insulin three times a day and since you cannot afford it you are forced to take two times a day. So we want that the government should look at this and give some subventions to diabetic patients then we will be very happy.
* Q. Are there time when you were unable to acquire your medicines prescribed in the hospital?
1. Yes in many occasions.
A. All the patients accepted they have had that problem.
* Q. Is there a time you went to the hospital and need a test and there was no equipment to do that test? That might not only be at Etoug-Ebe but in other hospitals.
4. Most of us have not gone elsewhere.
1. In Mundemba, equipment for blood sugar test was not. So i used to do it with a stick in front of the doctor so that he can analysed. In Mundemba, there are no drugs so i used to go to Kumba for them. Sometimes in Kumba they will say it is finished and will go to Douala. I think the drugs are not available in the district level to the reach of a common man. In Mundemba, many people are suffering with diabetes b/c of too much cassava. So I used to asked them to go to Kumba for test. I used to judge them from their appearance.
* Q. Do you think in Mundemba, the doctors there consult the same as in Yaounde? Do they give advice regularly on diet and things like that?

1. What happens there is that the doctors sent there are civil servants .They are not always present there. Most of the time, they spent in Kumba or Yaounde. You can see a doctor once in a forth night. These are some of the experiences that I got when I was there. There at Mundemba, were you given advice on your diet etc.?
1. I know that before going there.
* Q. Is there time you did not find a drug even here in Yaounde or in the pharmacy?
3. The monotard having prescribe you can move even six pharmacies you will not find.
* Q. Apart from the drugs, lets talk about the consultation conditions in the health centres. Do you think that it is overcrowded? The personnel is overworked or you think that it is OK. Do you wait for long hours when you go to hospital or the consultation is very free?
4. No, we have the diabetic rendezvous on certain dates. So we are given the priority on that day. So I think the people are working normally. They have arranged the work to suit us and to suit them also. B/c as soon as you reached, you are consulted. So it is not overcrowded.
1. I think it is overcrowded b/c diabetes is just like any other disease. If you can walk into the hospital and you are consulted and you go to your job site it will be good. Since it is from that job that you have money to buy drugs prescribed in the hospital. I remember when I used to attend the diabetic centre at Cité Verte. You go there in the morning and you come back at 4 PM. There, they prescribe drugs and the Nurses at the pharmacy will tell you to come at 3 PM, 3 PM you come, she says she don't have change. All that makes you angry. We are not only talking of Etoug-ebe which is a mission hospital, we are talking of government hospitals which is supposed to take care of us. We are crying that the government can even open a diabetic hospital . I think in some countries, they even give drugs free.
* Q. Any other suggestion to the government to improve the care of these patients like you?
4. The government should open more centres and supply drugs at a cheaper price.
3. If the ministry favour us with cheap drugs, it will be fine. The system of work in the central hospital is not good. Consultations are slow though patients don't need to eat. For a whole day only 10 patients are consulted and this can cause the dead of a patient.
* Q. What do you think is the cause of this diabetes?
4. I think it is a lot of sweet things, especially a lot of sugar in beer. Many people in Cameroon live on cassava, that is things from cassava have allot of starch which can cause this disease.
1. To me, diabetes is also got through inheritance. I know that one of my parents died from diabetes. When he died, I thought of witchcraft. It is only now that I have diabetes that I recalled he used to suffer from diabetes. When I was in the village, they used to give drugs to calm it. So the only way out is to know how to live with it.
2. I was operated and my pancreas were touched. So I think that is the cause of my illness.
3. My doctor said that too much sugar in the pancreas cause diabetes b/c the sugar is not well used in the pancreas. So I think that excess sugar cause diabetes.
4. People eat allot of sugar but they don't have diabetes. For example, the northerners who drink a lot of tea with excess sugar would have had diabetes.
2. I don't think sugar can give diabetes.
3. The majority of people suffering from diabetes said they were drinking alcohol like me. I was drinking a lot of alcohol and the doctor said there is a lot of sugar in the beer.
* Q. Do you think somebody who don't have diabetes can prevent having diabetes in the future? If so, how can he prevent this?

1. To me somebody without diabetes can prevent it by avoiding starchy food and also alcohol. He should have a balance diet.
4. I think it is not a matter of taking alcohol that can cause diabetes. But we need to consult the doctor to see that our pancreas are functioning well. But eating starchy food and alcohol does not cause diabetes but when pancreas dysfunction, you can have diabetes.
2. One of my brother made a general test to see whether he had diabetes or hypertension. So if people can do this test to see their state of health that would be good. Through the test if you find out that you are coming nearer to diabetes, you can prevent it.
* Q. Inside your household you have children who are big. If you go and test their blood sugar and find out that they don't have diabetes. What can you tell them to do? Do you need them to have diabetes before you pick up drugs to treat them.?
4. I would advice them to avoid a lot of food which have sugar in it especially drinks like coca cola, fanta etc.
3. The prevention of diabetes to me is complicated b/c when you take sweet things you have diabetes you don't take you have diabetes. To me I have to limit sugar.
* Q. Can your sister from the same mother have diabetes too?
4. Yes.
* Q. If she is not yet diabetic today what can you tell her to do?
4. I will tell her to be careful unless she will surely have diabetes. That she should try to take things in bits. The food should be maintained and respected.
* Q. Do you think people have diabetes more than others? Is it more women than men, more young people than old?
4. To me older people are more diabetic than young.
1. Urban dwellers are more diabetic than the rural masses. The rural masses work in the farms while town dwellers move only in vehicles, taxis, they eat canned food, fatty food. But in the village, they eat natural food. In America for example, a lot of people are suffering from diabetes b/c they live on tinned and canned food. I used to weigh 90kg, b/n 25--35 years. When people see me now they say maybe I am suffering from AIDS. So I have cut down my weight and I am feeling a bit fine now. I can trek from here to Nsimiyong. If I was in the village may be I will have diabetes at the age of 60 years.
* Q. What about b/n women and men?
4. To me men suffer more b/c most women avoid some food whereas men take all those things such as alcohol, tobacco etc.
2. Supported 4.
1. More women suffer from diabetes than men because many women have fats. They don't burn the fats in them. Fats block your blood vessels not to circulate well and you virtually have diabetes. But most women don't do sports, most of them remain sitting. If you noticed some have diabetes when they are pregnant and after the pregnancy, they acquire it. Because your pancreas is under your stomach many of the women remain dormant.
* Q. Do you think that by having diabetes you have a high risk of having heart diseases?
1. Yes, the first thing is that your heart does not beat well. When I did not yet discover that I had diabetes, I used to run 1500 metres. When I left school and stopped, I developed diabetes. I could not run up to 50 metres. You see I am really tired, the heart cannot move as it used to do. I believe diabetes goes with heart problems.
4. B/c when you have diabetes, there are other diseases that follow. You can have Hypertension, dizziness, eye problems, articulatory and respiratory problems.
3. Hypertension can come if you don't follow your diet and do sports.

* Q. You have talked about risk factors which can cause diabetes. I assume all of you have had advice in your hospital on what type of food to eat. Is it easy for you to follow that diet?
4. It is not easy. When I work far from home I cannot cope with food. I cannot move with food. The food sold along the road must be prepared with may be too much salt. I am forced to eat a bit.
1. If you missed the period you need to take your food the sugar level will rise. If you are active in the service and you are in the forest doing some work and any thing you see you eat. Sometimes you are told to eat a bit and when you eat, you don't feel satisfied. When your head starts aching, you cannot more think. I do some calculation to know how much quantity of food I can eat. I can take some vegetables and some plantains and i feel that i have eating. It is difficult to measure the quantity but when i take too much i don't sleep.
* Q. Mr Atangana what is the problem you have with your diet?
3. The need to measure the food you have to eat. When you are hungry and you need to eat, you don't have time to measure the quantity. Therefore, when you eat what your stomach don't want i feel constipation. I tried with oranges, it was not going i abandoned it.
* Q. Still talking about food, I want to know your opinion about food. Is it the same thing you were eating at first or it has change?
4. I think we are eating the same type of food we were eating some ten years ago but there are things you have to avoid such as reduced salt quantity, reduced sugar quantity. If you want to drink tea you have to use a special sugar meant for diabetes. For those who move a lot, it is very difficult for them to respect 50% of diet. It is the same food but that other items have to be absent. We are told diamaore oil is not good and olive oil should be preferred. These oils depend on the organs.
* Q. The way you are eating, do everybody think it has change since ten years ago or it is still the same?
2. I don't eat the same. I have reduced the quantity of food I eat now. When I walk out i do absent from my normal meals. When I want to eat, I find out that it contains sugar. So i am not forced to eat any type of food.
1. Yes, why? B/c in the morning I have to take my tea and tea is taken with bread and sugar. All bread is made with sugar. Our boulangeries know that there are classes of people who don't eat sugar. It is only at Kalafatas that some bread is made without sugar. Sometimes you past there for three days, you don't find it.
* Q. Do you think that people eat more fatty food than before?
1. Yes, b/c if you visit hotels or homes you would find that people have the tendency to eat food which has allot of oil, eat sweet things, cakes and even chickens.
* Q. Those fatty food what can they cause?
1. You have cholesterol that goes to block the blood vessels. So you become diabetic and some may have heart attack.
* Q. Lets look at peoples' sizes. Do you think people are fatter now than before?
1. I think people are fatter now than before b/c people tend to appreciate somebody who is well structured and bulky than somebody who is thin. Therefore, people are fatter now than before.
4. I support his idea. Synthetic oil is produced now than our local oil which make people grow fatter.
3. When you have diabetes, you become obese. At the level of type one diabetes such as myself, I think my stomach have increase in size.
* Q. Do you think that size is good or bad?
3. To me taking size is good. It shows that you live well.

4. People are fatter now.
1. Fat is not a good thing. It doesn't show that you are living well. It indicates that you are moving towards a disease like diabetes or hypertension. I have a friend who used to laugh me that I don't take beer and I am so slim. He didn't know that I was a diabetic. There was one day that he had stroke on his jaw and his jaw was twisted to one side. He has tried to straighten it but just in vain. I told him that it is b/c of fat and I told him that i am a diabetic patient and eventually you may become one. You can also have eye problems.
* Q. Lets look at drinking. Do you think people drink alcohol now than before?
4. Yes.
* Q. Why is it so?
1. People say that when they have problems it is good they take some beer and forget about them which is not true. That is why they are drinking. If I was to elaborate a policy, i will even ask the company to be closed down. If you look at our television you see them been advertise several times. They don't sensitised people against them in the television. Another one is tobacco.
4. People drink more because they are unemployed. People have lost their jobs and they drink what ever they find b/c they are frustrated.
2. Those who drink much are those who have the means. If they don't have they wouldn't have been drinking. I suggest that people be sensitise but there is never a day you would say people should not drink.
3. We have not been told to do a particular sport, we have been asked to do sports.
4. In the urban centres people do sports and in the rural areas people do sports especially when they move up and down the valley to farms. So I think many people are doing sports indirectly.
2. There are countries that take care of patients, why not Cameroon? The resources are there but the government don't want.
1. The government should look for ways of acquiring new drugs. B/c I followed the CNN one day and the reporter a lady said that diabetic patients can now smile b/c some drugs have been discovered. May be it will take time to reach us here. If somebody is not there to spearhead, the drugs will not reach us here in time. The insulin that we are buying for 6.000 francs is expensive. If it can be reduced to 1000 francs, it will be good. We are crying that the medicines should be at our disposal.