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**DIVERGENT LEGITIMATIONS OF  
POST-STATE HEALTH INSTITUTIONS IN  
WESTERN EQUATORIAL AFRICA**

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Post-State Health Institutions in  
Western Equatorial Africa**

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# **Divergent Legitimations of Post-State Health Institutions in Western Equatorial Africa**

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Standardisation and organisational learning in health care provision in  
Uganda and Rwanda”

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## **Abstract**

This study examines the legitimation of power and knowledge in the struggle of public health and health care agencies in the Lower Congo region of the Democratic Republic of Congo to vanquish chronic tropical diseases. Of particular interest is the creation of alternative institutions following the collapse of state sponsored structures and supply lines in the 1980s and 1990s, and the process by which such alternative structures are legitimized. A review of legitimation theory suggests that new paradigms are required to assess the nature and efficacy of diverse non-state institutions within a fluid global neo-liberal context. The paper argues that these new or newly adapted post-state institutional arrangements, born in the crisis of state failure, may be effective in the lessening of the disease burden that weighs on the region to the extent that they are able to muster the legitimacy of the populace, the professions, the national society, and the wider international community. I thus hope to shed light on the paradox of persistent tropical diseases – e. g., malaria, sleeping sickness, and schistosomiasis, as well as seasonal grippé, typhoid fever, tuberculosis and HIV/AIDS – as endemic or seasonal scourges, despite their being understood by local specialists, with known treatments and public health measures to control them.

## **Research Note**

The focus of this research was in the Territory of Luozi, also known as the “Manianga,” in 2013, in the Democratic Republic of Congo (DRC). The research was funded by a Fulbright (International Institute of Education) Senior Research Fellowship. Further research opportunities were provided in 2014 by the Deutsche Forschungsgemeinschaft Priority Programme 1448 “Adaptation and Creativity in Africa,” and the Max Planck Institute for Social Anthropology in Halle, Germany. I wish to acknowledge the generous invitation from Professor Richard Rottenburg, via Professor Steven Feierman to participate in the program.

## **Key Words**

Public Health, Healthcare, Legitimation, Alternative Structures, State Failure, Endemic Diseases

## Crisis and Creativity

The legitimation of power and knowledge is the lens through which this study examines the struggle of public health and health care in the Lower Congo region of Western Equatorial Africa to vanquish chronic tropical diseases (see figures 1–3). The collapse of state sponsored structures and supply lines in the 1980s and 1990s in Zaire<sup>1</sup> obliged health workers and policy leaders to radically reform the institutional framework through which such services were organized. They did so by creating or renewing an array of alternative institutions: lower governmental entities, churches, international and local NGOs, private enterprises, and ad hoc coalitions. The broad question this work poses is: How do the practitioners and policy-makers in these diverse institutional arrangements go about governing them in the pursuit of a common goal, the maintenance of, or improvement of public health and healthcare; and, How are these non-state agencies and structures, and the knowledge and expertise they must carry, legitimated by the populace, the national elites, professionals, and by international partners? **The contribution I make here features the creativity in play when the state fails and people who care need to ramp up their alternative structures and initiatives to maintain and improve health. At the same time this process shows the limits of what can be done within a weak state, and a neo-liberal global economy.**

The proposition I am putting forward is that the new arrangement, born in crisis, will be effective to the extent that they are able to muster the legitimacy of the populace, the professions, the national society, and the wider international community. Legitimation theory has classically been applied to the state. However, given the circumstances of state fragility before us, newer, more flexible notions of social legitimacy are needed to understand the nuances of institutional and social movement efficacy in addressing the dilemmas of chronic disease. With such more nuanced set of analyses in hand, I hope to shed light on why some diseases appear to be decreasing in frequency (e. g., protein malnutrition) or are only sporadic in their outbreak (e. g., sleeping sickness), others are increasing (seasonal flu, grippe), and most continue at significant chronic levels (e. g., malaria, schistosomiasis, typhoid fever, tuberculosis and HIV/AIDS) despite their being understood by local specialists, with known treatments and public health measures to control them. This analysis has both a practical and a scholarly or theoretical goal: to illuminate the requirements, beyond current measures and infrastructures, needed eliminate or significantly diminish the mentioned diseases; to illuminate scholarly perspectives on the pluralistic – especially non-state – institutions involved in health and healing.

The singular crisis in our story is the collapse of the Zairian / Congolese state in the 1980s and 1990s. This did not occur all at once, nor was it ever total. The phenomenon of state “collapse” must be seen here, and in other cases, as occurring sector by sector, region by region, and in particular time periods. The Lower Congo region of this study was never the scene of civil war, nor was it ever occupied by a rebel army during the 50 postcolonial years. It is situated relatively close to the Kinshasa and the major national port of Matadi, thus enjoys relative access to the economic and political hubs of urban national centers. Local government officials continued to occupy their offices throughout the postcolonial period, carrying on the daily

1 With the overthrow of Mobutu in 1998, Zaire was changed back to Democratic Republic of Congo, the name of the newly independent country from 1960 to 1965. In this paper Zaire and DRC will be used alternately as appropriate for the historical period.

tasks of administration. State “collapse” here meant slim or missing tax revenues; fiscal crisis that rendered currency worthless; non-payment of salary and pensions, obliging servants of the state to make their living another way. Thus, even in this relatively peaceful setting, by Central African standards, events of the 1980s and 1990s forced regional elites and healthcare practitioners to create alternative structures to administer hospitals and clinics, and to find finances for their operations.

The paradox of this story of crisis in institutions and society and the focus on health, is that the ephemeral quality of institutions provides the fertile ground for creative solutions. Whether out of desperation or opportunism, the loss of legitimacy and ability of one set of institutions calls forth the effort by individuals and groups to create alternatives to carry out the much desired service. Ad hoc coalitions of individuals and organizations have sought to pick up the slack left by the failing state. The challenge of endemic diseases and the desire to promote health has brought into being a series of creative initiatives, social movements, institutional innovations, and entrepreneurial ventures. The cultural “seed” of this process of creative re-legitimation from within society is the deeply rooted notion that the chaos of failed authority is perceived as a sickness that may be healed by the assertion or re-creation of authority, order and justice. The outward manifestation of such efforts is found in rituals such as the *dumuna* triple leap, social movements or collective actions inspired by prophets, priests, institutional leaders or “big men and women” who in one form or another claim transcendent power of ancestors, former leaders or visionaries, nature spirits, the Holy Spirit or God. The history of Kongo is dotted with such renewals and visions of dilemmas resolved (Janzen 1977; 1982, 323–6).



Figure 1—Population numbers of Luozi Health Zone; malaria cases seen at all health posts, centers, and the referral hospital, and death rates from malaria. Luozi Zone de Santé, 2003–2012.

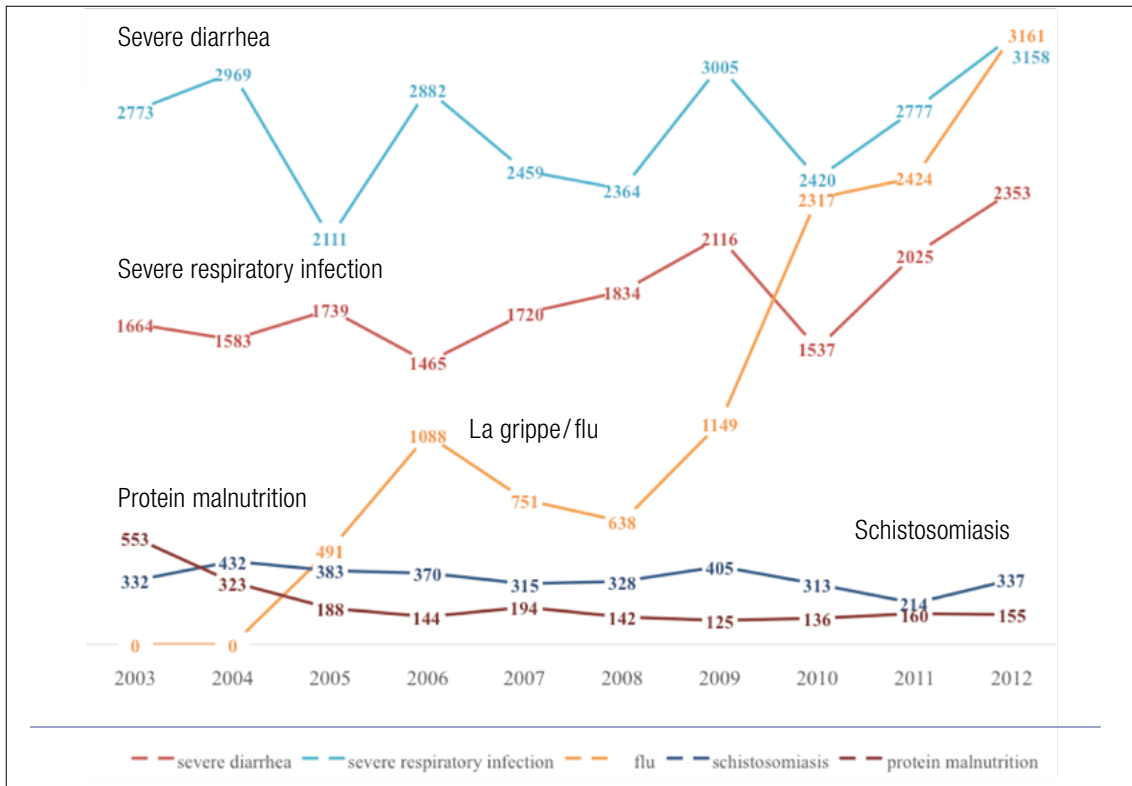


Figure 2—Numbers of cases seen at all clinics, centers, and referral hospital of all other principal diseases, Luozi Zone de Santé, 2003–2012. Protein malnutrition shows a significant decline from 533 cases in 2003 to 155 in 2012. Seasonal “flu” (grippe) is the only tracked disease that shows a marked increase, from 65 cases in 2004 to 3161 in 2012. This is the global flu.

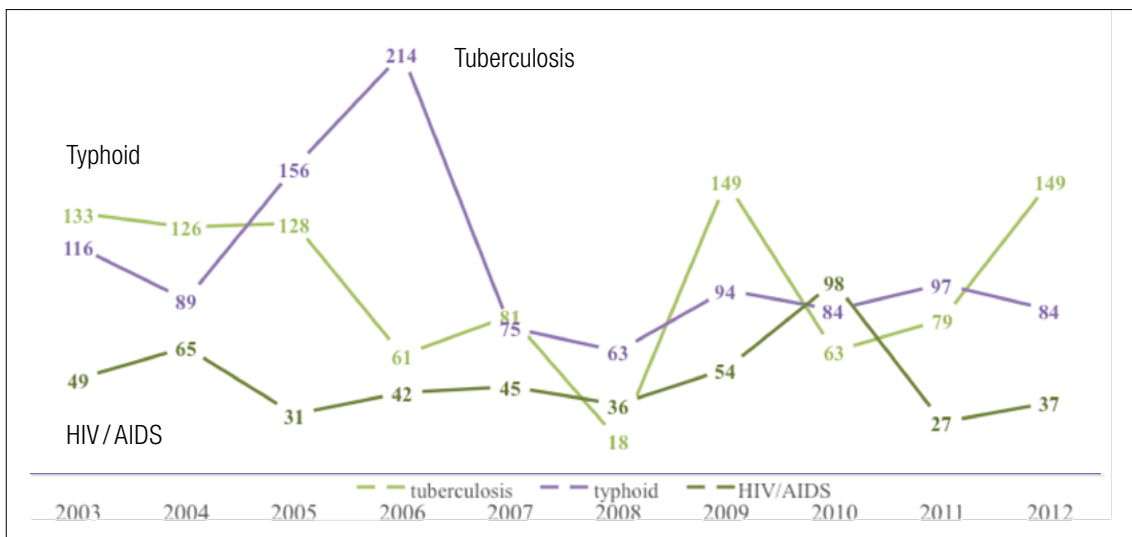


Figure 3—Numbers of cases seen at all clinics, centers, and referral hospital of all other principal diseases, Luozi Zone de Santé, 2003–2012. These three disease have the lowest frequency of “principal diseases” of the Health Zone of Luozi. HIV/AIDS has been targeted by numerous international NGOs; Health Zone and medical personnel thought many cases went unreported until they became critical. Tuberculosis is considered easily treatable with antibiotics; drug resistant TB has not yet appeared in the region, although personnel were on the lookout for it.

## Postcolonial Institutional Devolution

Across the DRC, a number of state institutions that had emerged at independence in 1960, or soon thereafter, experienced either gradual or more sudden decline in the 1980s due to loss of financing, mis-management, or both. Entire sectors of government-run life came to a standstill. Some were simply abandoned, and life went on without them. This was the case with the postal system. Others were replaced by alternative structures. This was the case with the Université National du Zaïre (UNAZA), which had had campuses in Kinshasa, Lubumbashi, and Kisangani, each with a specialized focus, and research and training institutes to match. When funding dried up, this unitary model was replaced by dozens of smaller, private universities financed and administered by local leaders, churches, private groups, often with the support of international NGOs. The Free University of Luozi is an example of this type of institution.

The medical sector was similarly nationalized by the Zairian state under Mobutu; formerly mission or church operated institutions, or independent ventures, were incorporated into this national structure. A number of post-independence initiatives in public health were established in the 1970s and early 1980s in various parts of the country, at both Protestant and Catholic institutions—on a revised model of the FOREAMI health districts established in the 1930s. These served as models for the more systematic national program of primary health care initiated under the World Health Organization in 1984 (Baer 2007).

Following the spirit of the 1976 Alma Ata Declaration of „Health for All by the Year 2000,“ Zaire adopted the basic primary health program for decentralized “Health Zones” across the country; the Territory of Luozi made up three of the country’s 500 health zones. In the course of the 1980s, the zones were organized from the ground up. By the post-war era, in 2000, about half were administered jointly by the state and “faith-based organizations”, that is mission or independent church entities, many coordinated under the NGO network Santé Rural du Congo (SANRU) with international funding. In the spirit of the „Health for All“ resolution, basic care in the form of a trained nurse with essential drugs was to be accessible to all. No one was to have to walk farther than 15 km for this care. Each health zone was organized into local primary health posts, regional mid-level centers, and a central regional referral hospital. In the local centers nurses carried out basic care and public health initiatives such as children’s inoculations and care for basic illnesses. Ideally they were to see and refer the most serious cases up to hospital centers. Medicines and other resources were distributed from central stocks to the local centers. The entire Zaire program was coordinated under a national directorate headed by Martin Ngwete and his staff of Congolese and expatriate consultants (Bukonda 2014).<sup>2</sup>

Already at its inception, because of the unreliable nature of state medical supplies, the Primary Health Care system in Zaire was purposefully created with multiple, redundant, supply networks parallel to the government sources (Tshimika 1991, 1995, 2000; Janzen 2002, 255–257).<sup>3</sup> These arrangements allowed hospitals and Health Zones to negotiate separate supplies from international or private sources. The wisdom of such dual structures was justified by the turbulence of the wars and governmental changes of the 1990s.

2 Dr. Ngoyi Bukonda, professor of public health in Wichita State University, was a student of Dr. Ngwete’s and advised in the work of these health zones. Dr. Franklin Baer was one of the expatriate consultants of the unfolding Zairian PHC program, a role that continues till the present.

3 Dr. Tshimika, PhD Public Health, was instrumental in the creation and revitalization of the Health Zones in the Bandundu Province of Zaire/Congo, whose capital is Kikwit.



By the late 1980s, the Zairian government's role in the Primary Health Care system, as in every other service sector, deteriorated. Inflation soared to 1000%/year; in one two month period there were five Ministers of Health. The entire national budget became unreliable. At this point the government effectively and by default got out of the public health and health care business entirely. The Ministry of Health became non-functional, like other ministries of the Zairian government. Observers began to speak of the „collapse of the state.“ The 1991 riots in Kinshasa by Zairian soldiers and the destruction of many private enterprises brought the country into a state of deep moral and economic crisis. Along with the collapse of infrastructure such as the postal system, roads, and ferries, now too the primary health care zones fell apart because governmental workers were no longer paid, or if paid, their salaries were as worthless as the hyper-inflationary currency. After the 1991 riots foreign partners like United States AID, Canadian CID, Belgian assistance, and organizations like OXFAM and UNESCO withdrew because it became impossible to conduct their affairs in the midst of such chaos. In 1993, the Primary Health Care directorate in Kinshasa was pillaged by soldiers, medicine stocks were stolen, vehicles were taken, personnel abandoned their posts.

Local supervision by motivated and interested individuals became everything in new efforts at public health. In this sector, as in education and food production and distribution, private initiatives and faith based organizations were all that was left. Where village nurses understood the issues, local clinics survived. The same was true of hospitals and clinics. But many of these now of necessity became fee-for-service operations, dependent on their local constituency, students or patients, all the while searching for support from outside agencies of the church, the United Nations, or other private sources. In Zaire and elsewhere in Africa, the NGO became the structural where-with-all of health care delivery.

The legacy of this crisis of the Zairian state carries over to the post-Zairian RDC state. It is reflected in continuing minimal public funding for public health and healthcare, which means the necessity of private financing for healthcare and an increasing disparity between those with means and those without. The chart below shows the sharp contrast between the RDC and Botswana, the African country that demonstrates the highest public expenditures for public health and healthcare (World Health Organization 2012).

Country & support for public health & healthcare	% of GNP for health & healthcare expenses	% of health spending from public funds	% of health spending from private funds
Congo DRC	3.7%	0.9%	99.1%
Botswana	4.2%	61%	39%
USA	13.7%	44.1%	55.9%
Germany	10.5%	77.5%	22.5%

*Scholarly Debates on the African State: Failed & Rigorous*

Many scholars have weighed in on the collapse of the state in this particular African setting and in other state settings. Only the general outlines of this literature can be reviewed here, insofar as it is relevant to grasping the unfolding picture of public health and healthcare infrastructure in the Manianga, the Lower Congo, and beyond. James Ferguson's phrase of the "shadow

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state” (2006) catches an important dimension of state weakness, its presence as a structure of bureaucratic and political roles, but without the economic strength to achieve the services and presences expected of states. Ferguson relates this “shadowiness” to the neoliberal economic pressures that open service sectors to global commoditization, governed by the reach of large global corporations. Fiscal tightening imposed upon African and other states by the “Structural Adjustment Programs” of the World Bank and the International Monetary Fund have been seen as particularly crippling for the health and healthcare sector. Increases in chronic diseases, the rise of malnutrition in children, and the general “immiseration” of the poor have been traced in study after study as a result of such fiscal belt-tightening at the national level (Pfeiffer and Chapman 2010, 149–165). Other more indirect impacts upon public wellbeing include: the imposition of fees for healthcare services, cuts to public sector services such as education, agriculture, water and public works; unemployment caused by layoffs of public sector workers and income declines resulting from wage cuts for those remaining; privatization of state industries that often leads to layoffs; removal of state subsidies for essentials of food transport and food price increases; currency devaluation, and generally increases in inequality (ibid., 152). Critics of structural adjustment emphasize that health is not a commodity that can be economized for greater profit and economic development; it is a right, or at least a basic human need that is compromised if its infrastructure is short-changed.

In any event, all of the adjectives used by scholars writing about failed African states apply to the DRC, a state that is variously “shadowy” (Ferguson 2006), “fragile” (Fund for Peace 2012),<sup>4</sup> “hollow” (Rusca and Schwartz 2012), or “crumbling” which in the case of the DRC amounted to a post-2011 presidential election paralysis which brought charges of gutting the electoral process with parliamentary manipulation, ballot rigging, lost ballots, and hasty certification by an apparently bought-off electoral commission (Dizolele and Kambale 2012). The particular reasons for the state’s failure go well beyond outside-imposed fiscal tightening of the 1970s and 1980s. Mobutu’s Zaire was a classic case of the patrimonial state in which the elite helped themselves to the basic resources of the land and doled out favors to their friends and dependents in exchange for loyalty, some services, and support, rather than to invest in systematic development of essential services such as education, healthcare, communications, urban development, and roads. The patrimonial state, in this kind of scenario, is described as a structure of personalized patron-client relations. Under such circumstances, some analysts claim, “development” does not take place. The productive resources of a land are drained off into personal ends, deposited in Swiss banks. This is the standard understanding of “corruption.” A different understanding of the patrimonial patronage state is held by Chabal and Daloz in their book *Africa Works* (1999). According to them, the very chaos that ensues from structural adjustment or other types of disorder becomes itself a resource that may be managed as patronage. This is not the kind of development that development experts intend, but it is nevertheless a political system that seems to thrive. Elites translate social disorder into patronage resources that shore up the loyalty of their client networks, as they “help” their friends and others who are loyal to them. Furthermore, Western style development does not undermine the viability of “neo-patrimonialism” (Gerhart 1999). Although it is antithetical to the public interest, this kind of patronage “works” as a system of maintaining power.

4 The DRC placed between 2nd and 5th most fragile state, after Somalia, Central African Republic, and South Sudan.

But the DRC was not the only state to experience such a decline. Many states across Africa and elsewhere felt the transforming winds of loss of confidence in their ability to serve the needs of their citizens. There was a major shift in the 1970s and 80s from attempted state-sponsored health programs to other kinds of arrangements that were sometimes called “public-private partnerships,” outright “privatization.” Privatization of major sectors of the economy and social services was usually accompanied by the rise of the project-specific non-governmental agency and the out-sourcing of services, including healthcare (Rusca and Schwartz 2012). These moves were usually accompanied by the rise of neoliberal economic regimes and “global health” (Geissler, Rottenburg, Zenker 2012, 8–9). Thus, the weakening of states in the decades of the 1970s to the 1990s was usually accompanied by an ideological shift on the part of international donors from working through state structures to working directly with NGOs or with project-specific goals that ignored or bypassed local and national jurisdictions. In this regard the DRC was not exceptional, but rather super-typical.

And yet several African states during these same years succeeded in wielding strong state structures to enhance public health and healthcare programs. Botswana, where 60 % of overall health and healthcare expenditures were state-originated, was the first African state to offer free AZT medications to HIV+ sufferers (Mogaie 2010). In Uganda, strong state-sponsored initiatives brought HIV/AIDS infection rates down from 35 % to 5 %. Similar coordination of national public priorities led to the containment of the Ebola outbreak in Gulu in 2,000, resulting in 425 infections and 225 deaths, within four months through coordinated national public health measures, international agency intervention, and close national monitoring of the isolation of infected individuals, the tracking of suspects, and laboratory testing (Opira 2014). Rwanda represents a third example of significant state coordination in public health and healthcare, as in other service realms. With the use of systematic digital record keeping, Rwanda has launched an initiative to track child health in local centers, and to monitor the results of other health improvement campaigns. One of the dramatic goals in this initiative is to eliminate chronic malaria (Schraepel 2014). Scholarly awareness of strong states or the analysis of areas of effective governance in Africa has been recently supported by work such as Bierschenk’s focus on effective bureaucracies or projects in Africa (2014). We are thus confronted with a great range in the effectiveness of states and state functioning.

The question therefore becomes, in our understanding of public health and healthcare in the Lower Congo, how do we understand the hybrid institutions in which the structures of a weak state are shared with the structures of alternative administrative entities.

## **A Closer Look at the Alternative Structures for Public Health and Healthcare**

An enumeration of all the institutional structures that in some way carry public health and healthcare in 2013 would include the following: several different types and levels of governance: (1) the most local of all, the villages and clan communities of the landed estates, each with at least one land chief, *mfumu nsi*, in charge of the most precious resource of all, cultivable land; (2) local governments like the villages and sectors, the “extra traditional” jurisdictions like the town of Luozi, and in larger cities, their communes; (3) the Health Zone system, implemented

in 1985 on inspiration of the World Health Organization, adopted in 1992 as the framework for the new Catholic and Protestant health services, which were in turn resurrected from former mission-directed healthcare services, now administered as a department of the denominations and parishes; (4) the parastatal organizations such as REGIDISO, the waterworks seen in towns and cities, in process of being privatized; (5) the coalition of the region's power brokers that brought the waterworks into being; (6) Congolese NGOs, such as the numerous educational institutions and development organizations that train students in sciences and other liberal arts; (7) international NGOs that care for special health conditions such as the WHO's attention to polio; (8) additional NGOs that focus on HIV/AIDS, and the regional medical team that deals with trypanosomiasis outbreaks; (9) private business men such as pharmacists who both produce medications and as merchants import drugs that they sell to the public; (10) prophet-healers and herbalists who provide a broad-based popular service that is trusted but also pricey, including divination of the causes of misfortune, protection from spiritual and temporal aggression, as well as plant-based medicines; (11) finally, the shadow government that provides a nominal coordination of services, some legal cover for professionals, and occasionally funding for special projects, but less than one percent of all healthcare expenditures.

## **Health Zones as Framework for Institutional Consolidation**

In the Manianga, and many other regions, the collapse of the Zairian state brought back into the business of managing health care the only remaining corporate structures with any substance and scale, namely the churches. But the institutional platform for this resurrection was the recently created and much heralded Health Zone infrastructure. In the Manianga (Territory of Luozi) Protestant and Catholic medical departments were organized in 1991 with semi-autonomous status and responsibility of administering the institutions within one or across several Health Zones. Although this move seemed to restore the church-related medical work to a status similar to the missions of colonial days, there was a big difference. Now all or almost all personnel were Congolese professionals. Also, the way the medical directorates took charge of the Zones was not the overlapping, sectarian and competitive manner of the colonial era. Across the DRC, about half of the health zones were administered by church organizations. The rest were state administered. The state-private-church partnership model prevails in many respects in all Congolese health-related endeavors, as is evident in the institutional affiliations below in the three health zones of the Manianga.

Thus, out of the shambles of nationalized institutions, old buildings and organizations were resurrected to create a viable, if uneven, system of public health and healthcare. The eclectic nature of institutions that were incorporated into the post-1984 structure of Health Zones is evident from the following picture of institutions in locales, their affiliations, the bed capacity, and number of physicians in each as of 2012 (Territoire de Luozi 2011; see Figure 4).

In the Southwest of the Territory of Luozi, the CEC Protestant Health Department administers the Kibunzi Health Zone into which are incorporated the following institutions and capacities.

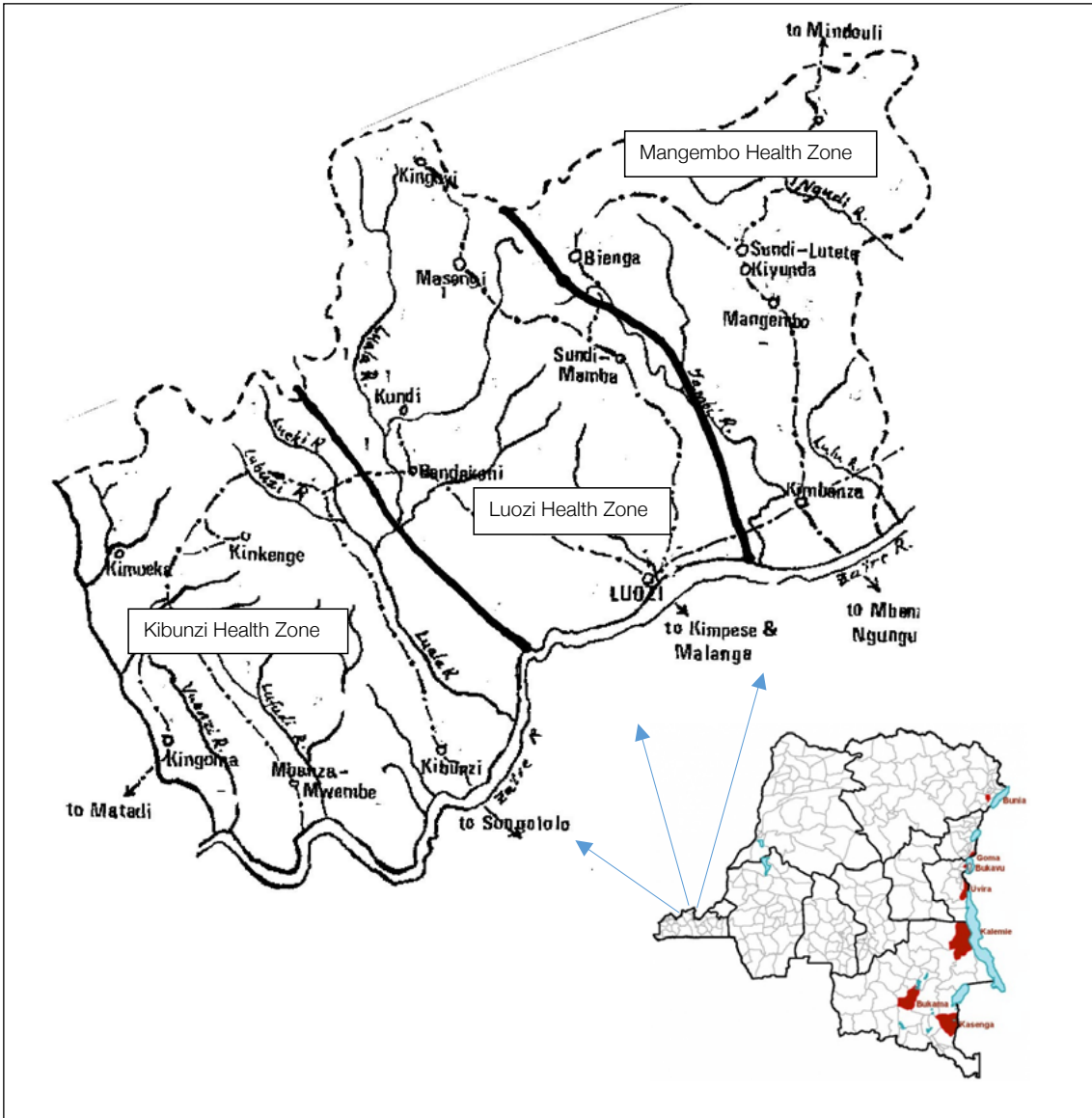


Figure 4—Health Zones of Kibunzi, Luozi, and Mangembo within Territory of Luozi (the Manianga), Province of Bas-Congo, Democratic Republic of Congo. Detail at right, the 500 Health Zones in the DRC. Arrows identify three Health Zones in the Luozi Territory

Locale & Institution	Affiliation	Bed capacity	Number physicians
Kibunzi Referral Hospital	CEC Protestant	70	2
Kinkenge Health Center	CEC Protestant	60	1
Kingoma Health Center	Catholic Church	45	1
Kimuaka Health Center	Private	47	0

In the northeast and east of the Territory, Catholic Church’s Medical Service administered the Mangembo Health Zone, that incorporated the following institutions and capacities.

Locale & Institution	Affiliation	Bed capacity	Number physicians
Mangembo Referral Hospital	Catholic Church	60	2
Sundi-Lutete Health Center	CEC Protestant	60	1
Sundi Mamba Health Center	CEC Protestant	20	1

The Protestant CEC Health Department administers the Luozi Health Zone that incorporates the following institutions with their affiliations and capacities.

Locale & Institution	Affiliation	Bed capacity	Number physicians
Luozi General Hospital	State	119	2
Luozi Catholic Sisters	Catholic Church	68	1
Nkundi Health Center	State	54	1
Kingoyi Health Center	CEC Protestant	55	1

The challenge of these ecclesiastical-medical agencies is to coordinate historically well-funded institutions with all their buildings and personnel with a fee-for-service income, alongside the very minimal 0.9% of public health and healthcare expenditures for childhood vaccinations, HIV/AIDS campaigns, sleeping sickness, and a few other "dangerous" diseases. This means that everyone is strapped. All other medical care in hospitals and centers is charged to users. The face of all this is a kind of paradox of widely available services and medicines, but at prohibitive prices, leaving many communities inadequately covered. At the personal or household level it means that a large piece of the annual pie is spent on medical emergencies. At the institutional level it means all vigilance must be exercised to extract operating funds and salaries from patients, or from other sources as each institution or service can find it.

The regional Health Zone thus became the effective framework for both public health services and the coordination of healthcare institutions after 1991. Some of the 500 health zones across Congo collapsed as wars broke out, personnel fled, buildings were destroyed, and all activities came to a standstill. In Lower Congo, largely spared direct impact of Congo's civil wars, the health zone structure survived and became the framework for the work of the church-based medical services. A closer look at the Luozi Health Zone, one of three in the Luozi Territory, will offer insight into how this structure was intended to function, and how it fared alongside and intertwined with the Protestant and Catholic health agencies.

The Luozi Health Zone, following the prescription of the WHO global Primary Health Care program, was divided into Health Circles (Aires de Santé) each with at least one Centre de Santé, one or more Postes de Santé at the lowest most basic level, and one central referral hospital. Thus, in the Luozi Health Zone (see Figure 4), there are eleven Centres de Santé, each with from one to eight Postes de Santé (for a total of 54); Luozi General Hospital is the referral hospital for the Zone.

The Public Health agency of the Luozi Health Zone operated out of a building facing the Luozi Referral Hospital, its official name was "Zone de Sante Rurale Luozi Bureau Central." This non-descript building housed a reception room, and several meeting rooms on either side of a long corridor. In each of these meeting rooms, with chairs around a table, were on one

wall shelves or cabinets with folders or reports. On free walls were taped large sheets covered with the names of the Aires de Sante on the left, and numbers in columns with titles flowing across the sheets: population and cases treated, vaccinated, or seen, or not seen. These were the working documents or progress reports of various campaigns of recent years: Polio Vaccinations 2008; Maternal & Child Health Indicators 2011, and so on. This record keeping of the Health Zone reflected the extensive monitoring operation of diseases and conditions reported by the Health Posts, the Health Centers, and the Referral Hospital. Periodically each Health Post needed to fill out a basic report of its activities, number and type of patient visits, diseases or conditions shown, medications or treatments given, and results. This information was passed to the Provincial level and ultimately provides the World Health Organization with the basic information for its global reports. As the goal of “health for all by the year 2000” (WHO 2000) came and went, the same reporting techniques and compilation formulas continued to be used.

The Health Zone staff functioned as the eyes, ears, arms and legs of the entire medical establishment. The *animateur communautaire* and the *infirmier superviseur* would go off on their motorcycles to visit far flung health posts and centers to check up on the resident nurses, to encourage them, to monitor supplies, to follow through on campaigns or consultations, and to collect records of all these accomplishments. Their secretary stayed at the office to record the documents they brought back from their trips into the Zone hinterland. They sometimes commented on particular series of figures as being the result of their own field trips and surveys where they thought the existing record-keepers were not finding and counting everyone. I noted that the mortality rates of the Health Zone were far lower than those reported in the Territorial Annual Reports, whereas the birth rates were comparable. Every health post had a group of volunteers who were charged with encouraging the local community to use the post for their health concerns, to report births and deaths. Global experience by the World Health Organization with grassroots participation in public health campaigns had led to this feature of local volunteers being built into the Primary Health Care structures already in 1984.

The Luozi Health Zone public health program, like the WHO in general, emphasized the health of women and children. Childhood vaccination campaigns constituted an important part of their outreach. Children’s nutrition was a further important feature of the entire complex of practices: maternal health visits, birthing, neonatal care, inoculations, and nutrition. The animateur and the nurse were particularly concerned that the Vitamin A supplement would be properly administered, and that children be protected from the anemia that often accompanied malaria attacks. They also distributed medicated mosquito nets to everyone.

WHO statistical expectations were keen to record the percentage of the population that actually participated in various campaigns. These figures became part of the “Indicators of Health” scores that measured progress toward health development. Health Zone personnel in general were sensitive regarding non-participation in vaccination, child care, nutrition, and supplement programs, and engaged the volunteers as much as possible to benefit from them. However there were nay-sayers, principal among them the Bundu dia Kongo nativistic nationalists who see any and all programs that inject, instill, or encourage outside materials or ideas as a conspiracy to control and dominate them. The BDK is now banned, but the paranoid sentiment of rejecting public health is fairly widespread.

## Hospitals, NGOs, Churches: Tapping the most Rigorous Corporate Base

The major player in healthcare in the Territory of Luozi is the Department of Medical Works (Département des Oeuvres médicales, DOM) of the Communauté Evangélique du Congo (CEC)<sup>5</sup>, the Protestant church that succeeded the Swedish Covenant Church mission *Svenskamissionsförbundet* (SMF) in 1961 (CEC 2012). Its Catholic counterpart administers the Mangembo Health Zone from the hospital at Mangembo. The work of the DOM offers an example of an earlier-existing agency resurrected to take over the functions abandoned by the Ministry of Health of the collapsing Zairian state.

Headed by Dr. Alfred Monameso, MD, MPH, from its headquarters in Luozi, the DOM staff includes a financial assistant, a technical assistant, an accountant, an assistant for logistics, a pharmacist, a secretary, and a chauffeur. The DOM administers two general referral hospitals (Luozi and Kibunzi), five Health Centers (Nkundi, Kingoyi, Kinkenge, Sundi-Lutete, Sundi Mamba), 36 Health Posts, two medical technology institutes. Further, in Matadi it administers three medical centers, and in Kinshasa two medical centers. It is responsible for 329 employees including 14 physicians, 41 nurses, 74 nurse assistants, 80 auxiliary nurses, 16 laboratory technicians, one radiology technician, 54 administrative staff and 49 maintenance personnel. The DOM directly administered institutions in two Health Zones, and had institutions and services in four others Health Zones in the DRC in late 2012.

The historical background of this impressive medical organization is rooted in the more than a century of medical work by Swedish doctors, nurses, and other medical scientists, beginning with the campaign to eradicate sleeping sickness and establish the first biomedical work in the Manianga. The Congolese church that succeeded the SMF was officially created in 1961. The DOM was officially organized in its present form in 1991 in order to assume responsibility for the Health Zones that had been previously administered, since 1965, by the Zairian government. Although the medical work continued from 1965 to 1991 in those institutions and services previously administered by the SMF and the Congolese successor church, little infrastructure maintenance and development was done during this time.

Therefore, in 1991 a series of initiatives were taken to restore to good condition the buildings, equipment, and stocks of the institutions under DOM responsibility. From 1991 to 1996 (Project PROSAN III, at a cost of \$419,714), six hospitals (Luozi, Kibunzi, Kingoyi, Nkundi and Sundi Lutete) were freshly equipped, 40 health posts were constructed and equipped; all medical personnel were given a medical refresher course (CEC 2012, 7–8). Also, beginning in 1991 (project PROHOPITAL, for \$283,428), was undertaken the rehabilitation or construction of a medical internist pavilion, an old dispensary, a pediatric pavilion, sanatorium and toilets. This project included the purchase of an ambulance, 50 hospital beds and mattresses, one electrical generator. At the same time (project PROVEHICULE, for \$76,000) were purchased two vehicles for Kingoyi and Kibunzi hospitals one motorcycle for Luozi, and ten bicycles for health posts.

In 1994 and 1995 further initiatives were taken, including the construction of physicians' residences in Luozi (\$24,571) and for the medical director of Sundi Lutete (\$58,515); the

5 Previously called the *Eglise Evangélique de Manianga et Matadi*, EEMM.



construction of a nursing school and institute of medical technology in Luozi (\$33,285). In 1996, for \$50,000, there were further purchases of a generator and two stabilizers and electrical wiring at Kibunzi. In 1999, for \$24,857, a pharmacy in Matadi was equipped, and medical stocks were purchased.

In 2000 to 2002, for \$156,817, eleven hospitals and medical centers in the Territory of Luozi were equipped and units created to deal with malnutrition and nutritional rehabilitation. In 2000, for \$42,861, pharmaceutical stocks were purchased to resupply hospitals and health centers. In 2002–2004, for \$248,714, health centers at Nkundi and Sundi-Mamba were rehabilitated, including an ambulance for Nkundi, and a motorcycle for Sundi-Mamba.

Taking advantage of the urgency of the era, project PROLUSIDA, for \$770,724, from 2003–2010), and funds from international contributors, focused on an educational campaign regarding sexually transmitted diseases, particularly HIV/AIDS, and blood transfusion security.

DOM is increasingly self-conscious of its image with the public it is serving (70% of the Territory of Luozi), and how well it is doing vis-à-vis its competitors (CEC 2012, 10). In the Manianga these are the Catholic Medical Service, and the Salvation Army which has some parallel institutions not tied in to the Health Zone structure, and the healing churches (*bangunza*) and the traditional healers (*banganga*). The DOM has begun to look a little like a North American healthcare corporation. In its most recent synodal meeting a decision was reached to develop a logo for better identification and name-brand recognition. DOM is also explicit to its supporters and boards about which services create “loyalty” among clients. Apparently the pre-natal, post-natal, and child nutritional and care services, as well as childhood vaccinations, are regarded as loyalty-producing. Surgeries, too, have this effect, when the outcome is successful.

However, these services that people want, and which draws them to loyalty with these institutions, do not pay for themselves. Among the most lucrative are the sale of medicines, the maternity, and the laboratory (CEC 2012, 10).

DOM administrators and directors are well aware of risks to the organization and its successful future in the niche it has occupied since 1991 (CEC 2012, 11). Only seven of 14 physicians possess liability insurance provided by the state. The state supports only 69 personnel out of the total of 329. Buildings are in need of general repair. Seven health centers are in a condition of “advanced dilapidation.” Five of 9 vehicles are broken down. The Congo river is a big barrier to easy travel with the rest of the region. The population is impoverished, earning less than \$1/day.

Threats to the work of the DOM are numerous (CEC 2012, 14), including: weak participation of the state in the financing of health; lack of financial support for the work of DOM—other than direct fee for service; lack of structural partners; a population that often first consults traditional medicine; weak purchasing power of the population; elevated illiteracy in the population; resistance among adepts of the Bundu dia Kongo to mass health campaigns (e.g., vaccinations, vitamin A supplements); disruption of supply of basic and generic medicines in the central pharmacy; inadequate means of transport and communication.

The administrative and financial structure of DOM is considered by its directors to be unstable, anything but permanent (CEC 2012, 17). On the one hand it is serving a public that must pay for all services rendered, yet those services do not cover all costs. On the other hand, the sources of foreign funds that have supported some initiatives, are not guaranteed. This is the case with the Swedish Gemensam Framtid that supported some recent major initiatives. The Congolese state is a partner that could guarantee direct and indirect support: allocations for certain personnel, support for electricity, water, and other resources; indirect support in the form of tax relief, subventions, and much more. There is again a Ministry of Health that may be

lobbied to increase its support for the work of the DOM. The Strategic Plan of DOM commits itself to augment its negotiations for a contractual arrangement with these sources abroad and in the national state administration.

A final feature of the strategic plan is to promote health and wellness (CEC 2012, 18). This will be done by social marketing to the community, specifically in schools, to women, families, and youth. Institutional and community leaders must be sensitized to critical issues. Public health education will address hygiene and cleanliness, trash pickup, water usage, and sewage disposal. Finally, mutuals will be encouraged for health and healthcare cost sharing.

## **Luozi's Water Works & other Public Health Services**

The fragmentary character of public health structures and responsibilities is evident in the fact that major services of domestic water, sewage disposal, and trash pickup have not been covered so far in this paper on public health and healthcare. Perhaps these basic features of health are often handled differently from “medicine,” or “public health,” but in the Lower Congo the fragmentation of institutions, structures, and services is visibly evident.

In the course of interviewing Luozi chef de cite Matondo Lufinama, I learned that it is his city hall that annually does an inspection of the pit toilets that constitute one of three buildings usually found on all residential parcels (in addition to the house and the kitchen, sometimes there is a work shed). A city ordinance requires all homeowners to have a pit toilet. Indeed, this seems to be the case in most villages of the Manianga, at least going back to the 1960s, although in the health survey of 105 households some reported “going to *matiti* – the bush”.

Trash pickup is less well handled, although the procedure is known. In the Luozi market, at the edges of streets, and in some residential parcels, one sees piles of debris. In the market they are conspicuously swept into the middle of sidewalk-like aisles between the market stalls, so that one has to walk over or around them. Men with carts are hired weekly, Matondo stated, to haul this trash near the river where it is dumped – into the bush, not into the river.

The big story of public health improvement is however the installation of the Luozi Waterworks in 1993. Although the Luozi Waterworks serves individual parcel owners, it is definitely a public works project of major proportions that has a major impact on public health. Taps are installed in private parcels that have been purchased by the owners, sometimes from the original *chefs de terre clanique*, others from previous individual owners. Sometimes “concessions” are purchased by developers. Renting from the *chefs de terre* is also possible, or from owners. City water is purchased by each parcel owner. Each hydrant has a meter that counts water used. If one can't pay, their hydrants are shut off and fitted with a pinched end pipe. The water system covers most of the city, although Luozi's expansion has spread beyond the water system. A few areas have communal springs or wells with pumps. Several decades ago Luozi devoted a lot of attention and funds to this water works system.

Urban waterworks in the Congo are usually created and maintained by the parastatal organization Regie des Eaux (REGISIDO). This institution, like a few others in the DRC, has remained somewhat immune to the waves of corruption and dysfunction that have plagued institutions like the postal service (which has completely vanished), the Matadi to Kinshasa railroad (whose last train locomotive fell into a river), and Air Congo (that vanished in the 1990s). REGISIDO is now being privatized, as are all remaining state entities. Yet in its earlier operation, hydraulic

engineers and construction experts were able to install improved clean water in most of the Congo's major cities and towns, although rapid population expansion and settlement growth often overwhelmed the system. In the Luozi installation, REGISIDO engineers discovered a big spring flowing under the water into the river. It was tapped, cemented in, and brought in a ca. 30 cm pipe up to a tower and horizontally to the shore and to the pumping station. There, four pumps, powered by diesel engines, move the water up to the hydrants at each residential parcel throughout the town.

The story of how this water system came into being includes major political strategizing and pressure upon the government. Around 1988 the elite from the Manianga who lived in Kinshasa held a three-day meeting concerning improvements in their home area. One outcome was Batukezanga's illustrated book on the crocodiles of Luozi (1998). This was deemed good and interesting entertainment, but not sufficiently compelling to move toward a solution. Professor Kimpianga Mahaniah offered that more compelling picture (1989), including history, case histories of 100 persons killed by crocodiles (23 in 1987 alone), an explanation of the environmental causes for the increase of crocodiles (deforestation, loss of birds of prey to eat croco eggs, over-fishing of big carnivorous fish that prey on little crocos), as well as the folklore of croco-men and men with domestic crocos that herd fish and occasionally attack enemies.

In any event, suggested Diallo Lukwamusu (2013), the need for a water system in Luozi was very apparent with the water from the Congo river being polluted (non-potable) and the Luozi river being dirty, sluggish, and infested with schistosomiasis, and dangerous because of the crocodiles. The elections of 1990 (or thereabouts) provided the people of Luozi with the opportunity to make this their central cause, so the politicians picked up on it.. But the REGIDISO organized project was financed by the central government, thus probably authorized by Mobutu just a few years before the end of his reign.

Diallo noted that the system is vulnerable to mechanical breakdown and to ferry outages, since all diesel fuel comes via truck over the ferry! This vulnerability may be resolved the day Luozi and the rest of the region are electrified, although surely there will be issues of distribution, payment, and maintenance.

The presence of a pure water system in Luozi, even if flawed or disrupted sometimes for weeks or months, has made a noticeable impact on the drop in water borne diseases, especially infantile diarrheas and dysenteries, and also schistosomiasis. Within the town where water is available, diarrhea infection rates are half or less of what they are across the Territory of Luozi. There were no incidents of diarrhea or dysentery in our Intensive Sample households residing in Luozi.

## **Dumuna – the Legitimation of Power**

*We will thrive if the land thrives, but if the land doesn't thrive, we will have difficulty thriving as well.*

Jacqueline, grandmother of 26, household head, Janzen Household Interview, 2013.

*In the Congo, failure is not an option.*

Tata Kimpianga Mahaniah, founder, Centre de vulgarization Agricole; Rector, Free University of Luozi (2013).

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*Political legitimacy is rooted in the ability to fuse power and right in the service of the common interest*

Herman H. H. van Erp, British philosopher (2000, 197).

These diverse voices represent the multiple threads of an analysis of the legitimation formulations of the institutions and practices that shape public health and healthcare in the Lower Congo. The first is a maternal figure who states the popular understanding that individual wellbeing is tied to social wellbeing; thus, for individuals to be healthy, society – the land – needs to thrive. The second is a prominent educator, founding-president of a Congolese development NGO, and rector of the university that trains many health care technicians and caregivers. He strongly advocates resolve, not even considering wavering in the face of serious challenges. The third is a scholar who has reviewed earlier definitions of legitimacy and formulated his own understanding of the concept. Out of the diverse echoes of the popular, the elite, and the scholarly voices we may fashion our analysis of legitimacy in the setting at hand.

The legitimacy of institutions and their leadership has been an active concern in social science scholarship and writing for many years. “Legitimation theory” emerged to inquire into the ways that power came to be accepted, and thus legitimized, in society. Different types of authority became standard vocabulary in scholarship as well as public discourse. In Max Weber’s tripartite typology of authority (*Herrschaft*), “traditional authority,” (as found in archaic and local societies) was recognized by the legitimacy of custom, the acceptance in a society of having always done something in a certain way, presided over by elders or priests. “Charismatic authority” (as found in religious and political movements) recognized the impact of a society’s super heroes in offering justification for new ideas and constructions that entered into practice and norms. Scholars, and possibly Weber himself, judged such charisma to be in the credence lent a popular leader rather than in any intrinsic sense. Finally, “rational-legal authority” (as found in the bureaucracies of states and large institutions) represented the role of law, courts, and explicitly systematic procedures in the governing of a modern nation-state (Weber 1980). Weber’s foundational work came to be seen as increasingly problematic in late 20<sup>th</sup> and 21<sup>st</sup> century scholarship (Heese 1979) because of its exclusive focus on the state (Beethan 1991a). Modern secular states, large corporate organizations, and global political movements and networks required other kinds of perspectives. The “crisis of legitimacy” exposed by Habermas (1975), seen as a perpetuator of the Weberian paradigm (Isenboeck 2006) identified the dilemmas of modern secular society to provide a sense of solidarity such as that offered by nationalism, ethnicity, and religion – a “transcendent” quality or identity. He questions whether a complex secular society and secular state are even capable of offering individuals any meaningful identity. He has written (and continues to write) critical views of the European Union concerning the re-emergence of its sub-nationalities, despite, and therefore in contradiction to, its economic sovereignty.

Alternatives to the Weberian-Habermas state-centric understanding of legitimacy look at more basic attributes of socio-political organization. Beethan defines legitimacy as (1) the conformity of power to established rules, (2) its justifiability by reference to beliefs shared by both dominant and subordinate parties, and (3) evidence of consent on the part of the subordinate party (Beethan 1991b; Pierson 1992, 550). This analysis is particularly useful to our examination of Equatorial Africa in that he explores legitimacy in a number of settings outside of Western industrial democracies, including Islamic societies and non-legitimate expressions of state power, as well as legitimate and non-legitimate power entirely outside of the state. What we need, however, is theoretical formulations of non-state actors and institutions that take the place of the state in fulfilling services formerly expected of the state.

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The notion of governmentality has been put forward by a number of theorists to describe both state and non-state agencies, as “a range of forms of action and fields of practice aimed in a complex way at steering individuals and collectives,” allowing for “a plurality of governmental rationalities...depending on assumptions about starting points, means and goals, criteria of legitimacy, and acceptability” (Broeckling et al. 2011, 1–11). Governmentality, by itself, has been productively applied to situations with a range of non-state players such as international organizations (INGOs) and private entities. Ronnie Lipschutz extends the notion to not-strictly-state entities, noting that they draw their legitimacy from global civil society networks, and from the “capillaries of social power” (Lipschutz 2005). In other words, the combined presence of local jurisdictions, special-interest NGOs, and ad hoc initiatives constitute multiple legitimacies with a variety of bases of legitimacy. Such a diversity of governmentality is “associated with biopolitics... which is concerned with matters of life and death, with birth and propagation, with health and illness, both physical and mental, and with the processes that sustain or retard the optimization of the life of a population” (Lipschutz 2005, 236). Analysts Rusca and Schwartz speak of the “divergent legitimacies” (2012) that take the place of the “hollow state” in bringing international non-governmental organizations (INGOs) to deal with the all-important service of urban water provisioning. They point out that NGOs operating in many African settings have tended to seek legitimacy in the accomplishment of the task they set out to accomplish, rather than formal, normative or legal legitimacy, that is, recognition as legal within a host country’s laws. This has often caused friction between project output and normative legitimacy in NGO operations in development settings.

In situations where government fails entirely, other agencies must be introduced or called to life to deliver urgent services. Joanne Macrae, who addresses the post civil war situation, suggests that the most important feature of organizational or initiative legitimation is “finding a constitution for decision-making” (1997). In such conditions of crisis resulting from a power vacuum, “finding the constitution” means taking control of decision-making about the use of and distribution of (internal or external) resources, and whether that is agreed to by those most affected. Multilateral agencies can exert leverage in defining basic health planning, or a neutral party can mediate with local institutions. Where internal institutions such as those that emerged in the Congo to coordinate health care and public health after the collapse of the state (and its ministries) in the 1990s, the same qualifications for legitimacy will obtain; namely, do they represent a constitution for legitimate decision-making over resources?

A further socially embedded understanding of the legitimation of power is offered by Luc Boltanski and Laurent Thévenot who focus on the “critical moment” (1999, 360) when dissatisfied citizens object to a loss of voice, or a situation that upsets them, or they find themselves in a conflict with authorities. Debate, discussion, and the expression of grievances between the subjects and authorities, along with the invocation of a narrative rooted in former traditions or values, become a form of “justification” that yields a new legitimacy embraced by both parties to the dispute (1999, 360–1). In the Lower Congo setting such a “critical moment” would be the all too frequent times of citizens’ lament of the withering of the state, of their rulers’ abdication of responsibility, of the withdrawal of the state from its obligations.

The fragmentation of power in the Congo however gives us pause. Is the Boltanski-Thévenot model of the critical moment followed by debate, leading to the imperative of justification, at all fitting for the failed state situation where there is no one with whom the citizens can debate? The articulation of social theory around the absence of power, or the fragmentation of power needs to be carefully considered too. Kongo thought and political theory, which we shall examine shortly, has much to offer in this common situation. We will move to that perspective

via the central axiom of the Foucauldian paradigm, that the state shapes subjectivity, which internalizes bio-power. Geissler, Rottenburg, and Zenker in their *Rethinking biomedicine and governance in Africa*, warn against applying Foucault's framework reflexively, and reductionistically, simply because it has been so successful in other settings. This is especially true where dysfunctional institutions, and serious chronic diseases and poverty make an impact upon subjectivity, or power internalized (2012, 8–10), that is not the bio-power of a 19<sup>th</sup> century total institution, but rather the abyss in the wake of the collapsed kingdom, chiefdom, or postcolonial state. Can we envision the subjectivity of this biopower? This absence of state biopower may be seen as yielding to the upsurge of illegitimate diffuse and dangerous power usually referred to as witchcraft, both by the people and scholars such as Geschiere (1997) and Ashworth (2005), and in Kongo theories of power and legitimation.

The scope of social legitimation ideas and idioms in Kongo conceptions of health, and the practice of healing, cover much the same ground as the social science ideas explicated above. This is particularly the case since we are looking at institutions that must operate without the sanctioning of the state, or with a state that is missing or if present then toxic. Furthermore, some of the impetus for the operation of these initiatives and institutions arises from peoples' own convictions. In the absence of public financing or insurance coverage for health care, the question of who pays for medical services is of critical importance. A Kongo pattern of shared cost within the nuclear and the extended — lineage — family is supported by traditional convictions that such sharing is critical for the survival of the family line (Janzen 1978, 1987, 2002).<sup>6</sup> The creation and nurturing of alliances built upon marriage are also seen as essential for survival in time of health crisis. Education, professionalization, and emigration to a land of greater opportunity become part of this moral framework of the family and clan.

But as already mentioned, in Kongo thought and tradition there is a sense of the essential connection between sickness and social chaos, as well as its converse, health and social order. In the admittedly haphazard record of evidence of this equation, very often the justification for recruitment of an individual to a position of authority — chiefship, healer — is their sickness, in the form of a calling from the ancestor or spirit world. The initiation to such an office is then a therapeutic ritual that culminates in the endorsement of the individual by a wide circle of supportive alliances. The extent to which such a traditional order of both ideas and instituted roles or social arrangements exist today depends on particular circumstances,

The most explicit articulation of a structure of authority in Kongo society (and more widely in Central Africa) has been by put forward by Wyatt MacGaffey around four interrelated roles: the chief (*mfumu*), the prophet (*ngunza*), the priest or magician-healer (*nganga*), and the witch (*ndoki*). These four roles he speaks of as religious commissions, since they are all imbued with a transcendent dimension (MacGaffey 1970).

Chiefship in Kongo thinking is associated with a strong hand, resolute decision-making, the wisdom to resolve conflicts, and ultimately the will to use the sword — or poison, or other method — in the interest of the public good. Modern chiefs are but a faint echo of the image of the powerful chiefs of old. Mercantile traders and the colonial government destroyed the big historic chiefs who regularly had thieves executed, and even in their inaugurations are said to have killed kinsmen. Nevertheless, the image of the chief is that of someone who should have

6 In earlier work I identified this process as “therapy management” and the ad hoc but sanctioned set of individuals who came together to discern and accompany the sufferer through therapy as the “therapy managing group”. I have also discussed this process and the therapy managing group in connection with social legitimation.

the will to take life—literally or mystically—for the good of the community. A legitimate and powerful chief, or authority, was essential in creating a viable social order.

The witch, on the other hand, who also is associated with death and killing, uses power, including mystical means, for self-enrichment at the expense of the public good. In Kongo thinking about power, *kundu* is the visible physiological accumulation of life energy that a witch, *ndoki*, has taken from his victims. Detecting *kundu* was the one reason for performing autopsies on human cadavers in the pre-modern era. In more recent times *kundu* became a metaphor to describe the disintegrative effects of European colonial influence—e.g., money, power, education, foreign knowledge—that caused people to envy one another. In the ideology of this *kundu* power, an effective chief or family head should be able to bring together such assets—wealth, individual influence, knowledge—for the betterment of the community.

The prophet's role (*ngunza*) is that of a somewhat unpredictable critic of established power, of outside innovator, but with interests in the public good similar to those of the chief. The role of prophet, though not well documented, emerges no later than the 18<sup>th</sup> century with Kimpa Vita or Dona Beatrice, a priestess or prophetess who sought to restore the Kongo kingdom paralyzed by a succession conflict. The current lines of prophets date back to Simon Kimbangu and others who in 1921, early in Belgian colonialism, sought to revitalize Kongo society. Kimbangu and his adherents, and other prophets, were perceived as a direct threat to the colonial order and were mercilessly hunted down, imprisoned, exiled, and kept under close surveillance until the late 1950s, the eve of independence.

The herbalist-healer-magician (*nganga*) shares some of the outside innovate power with the prophet, but in a more technical sense. These specialists, historically and today, are masters of medicines and other techniques that address both physical and mystical issues such as divining the causes of misfortune, finding witches, neutralizing nefast medicines, and healing the sick.

MacGaffey expands his model of power in Kongo society to incorporate the work of Mary Douglas on the differences between legitimate and illegitimate power. All is in its effect and perception. Individuals may be seen as fulfilling either one or the other, depending on the context and outcome of their actions in furthering the public good. This is why operators of great technological feats are sometimes seen with ambivalence. They are good magicians or witches, depending on whether their contribution is perceived as public good or as robbing from the public for personal enrichment. Although old style powerful chiefs have not been seen since early colonial days, the picture of society given here continues to operate in the minds of many, and in some respects in institutions. The re-introduction of traditional chiefship by the postcolonial state reminds people of what chiefs once could do, although now they are the lowest rung of an administrative chain of command. Prophets and healers still are consulted to interpret misfortunes. If events in the lives of people are seen as caused by human ill will or social chaos, individual actors may be identified in order to neutralize them or to protect the victim from them. Although the accusation of witchcraft is regarded legally as serious slander, witchcraft identifications have occurred in recent years, with a few cases of mob killings during the chaotic pre-election year of 2008. In 2013 we were told of two cases of sudden deaths which friends and some family interpreted as mystical taking of life for personal gain.

All four of the Kongo commissions are believed to possess transcendental power, which may be either positive or negative, depending on the context and who is using it for what purpose. According to both the ethnographic literature and contemporary informants, standing over against the force of *kundu* accumulation, and *kiungu*, both negative qualities defined by “eating too much,” is the innate power of *mayembo*, that empowers the holder to locate hidden objects, discern the thoughts of others, diagnose a disease, or find or identify a thief (Laman 2000, 26).

Mayembo is a “quality of spirit” indicated by cramps or trembling of the body. It manifests itself in several modes: (1) controlled expression; (2) ecstatic outbursts of an unconscious nature; (3) that which comes suddenly with external stimulation, such as seeing something turning, hearing a steady rhythm or clapping on water. Many people’s *mayembo* induces crying, trembling, rolling on the ground. *Mayembo* is used to find sorcerers, evil spirits that are attacking someone, or interrogating spirits of the dead. Spirits of *minkisi* (*bakisi*) manifest themselves this way to come help kin of the possessed. Dancing, drumming, hand clapping, flapping a cloth can extend the ecstasy of *mayembo* to others, who also have ecstatic seizures. This technique is used to return the soul of a sick person to his body. Contemporary prophets (Mayangi 2013, Luyobisa 2013) enhanced the foregoing portray from Laman’s text of a century ago with several points, specifying that *mayembo* manifests itself in different places on the body: tingling in hands, what he feels before doing the rites of blessing, healing, and weighing of the spirit; twitching in shoulders, what a hunter feels before success in hunting game, due to the way he will carry his game home on his shoulders; twitching of eyes, before “seeing” spirits. He confirmed that this was how *bakisi* used to come to *banganga*, and how the Holy Spirit now comes to *bangunza*. This source of legitimation is signaled in the ritual of *dumuna* in healing, the blessing of inter-clan alliances, inauguration to chiefly office, and in the “weighing of spirit” rite of prophetic churches.

Both academic legitimation theory and Kongo thought and ritual share common features. Power may be legitimate or illegitimate, the former is used for the common good, the latter for personal gain against the common good. The common good in both traditions reflects the consent of the weakest member of society to actions taken by the most powerful, usually on their behalf. In some of the academic theories and emphatically in Kongo thought, a form of transcendent anchoring is also part of legitimate power. In Kongo theory, an important dimension of legitimate common good is the health of the polity, and by contrast, its absence is considered a form of sickness.

## The Divergent Legitimations of Contemporary Health & Healing

The foregoing ideas of social legitimation from social science and from Kongo thought may usefully be brought forward to interpret the effective ideas, structures, practices and personalities behind the public health, healthcare, and healing practices in North Kongo. The gap between satisfaction of services—full legitimacy and efficacy—and what the people perceive to be shortcomings—inadequate legitimacy, ineffectual services—is rather great in this region. Questions abound such as: How will the authorities deal with the absence of pure water sources in villages along the river? When will remote villages get health posts? The quality of food in markets? The entire infrastructure including roads, schools, and the economy? And on the part of the major health care providers, the new church medical authorities, how to make the people aware of what they are doing to provide healthcare? How is clarity established, or re-established in social relationships, particularly kin relations that often become tangled and contradictory? How is authority created in modern society? How can required health initiatives, the budgets, of public health measures gain the backing of the public? What experiments



or campaigns have been successful? Why have some failed? And a final cry for help: Why is the state so insensitive to its citizens?

The relevance of a legitimation backdrop is most apparent when it is directly associated with specific diseases or health-related interventions. The importance of pure water for drinking and relatively clean water for bathing is clearly at the forefront of Maniangans concerns, because of the clear connection they make between pure water and the absence of gastro-intestinal diseases like severe diarrhea in children, typhoid fever, and worse conditions like cholera. The importance of pit latrines is also linked in their minds to healthful living and the avoidance of other serious diseases. Local governance at the village, landed estate, and town level is responsible for checking up on these important infrastructures of the springs, wells, and water lines, and the pit toilets. The lineage heads, chiefs, and city administrators are either elected locally or appointed by provincial authorities. “Governmentality” at this level enjoys a robust legitimacy in which self-serving self-help suffices to maintain a fairly high level of healthful living. The absence of legitimacy is evident in the outcries of those who lack pure water sources. The failure of governmentality is evident in the broken down status of half of the pumps in villages across the region, pumps installed by NGOs without leaving behind the wherewithal to keep them in repair, or to generate a technical competence to sustain the system after their installation.

A vivid ethnographic illustration of the connection between individuals, technical education, specific actions, and legitimation is helpful. In Kisiasia village, Kivunda sector, North Manianga, the main sources of drinking water, springs flowing in small valleys, were cemented in with pipes in the 1960s when then-sector chief (communal mayor) Kusikila returned from secondary school, where he had learned about germs in biology class. He himself, with the help of youth, did the work on the springs. Forty years later, in 2013, the improved spring facility continued to be the main drinking water source for the villages. The two pumps installed in the village by an NGO that intended to make water more accessible, were both broken. Several clan/land estate heads had served and passed on their knowledge and authority to maintain the springs. Pit toilets, introduced in the late colonial period and at first resented, were later embraced by the communities as essential. New houses built since my earlier research in the 1960s all had accompanying pit toilets. Thus the local authority structures of the clan heads, the landed estate chiefs, and local sector chiefs or mayors maintained the health infrastructure insofar as the measures to control water-borne and sewage-related diseases.

The organization of the Luozi water works reveals a series of moves by various levels of the populace around a public attention to the crisis by public authorities, an appeal to the nation state, and direct intervention by the region’s representative, followed by the application of technical expertise. The rising rate of crocodile attacks on people at the river united everyone in a mass popular sense of urgency. The action by national parliamentarian Batangu Mpesa brought the issue to national attention, laying the legal groundwork for the temporary lifting of the ban on hunting crocodiles. His deft action to organize a hunting expedition on the river persuaded many that action was being taken to protect the people, although some still believed that the end of the crocodile problem was brought about by the withdrawal of sorcery. This series of highly visible actions ran parallel with the meeting of Luozi region elites in Kinshasa, and their effort to lobby the national treasurer to loosen the purse strings to actually fund the project. Finally, the public works engineers of REGIDISO followed through to actually install the system in the late 1980s. As an exercise in legitimation, most of Weber’s types of authority were invoked, including the charisma of the human-crocodile confrontation, with all its mystical connotations. The consent of the governed, indeed, the appeal of the governed, was invoked. However, the broad public concern generated did not translate into sustained bureaucratic-administrative

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formulas for funding the water installation. This entire effort at installing an urban pure water system may be seen as a somewhat ad hoc episode of broad resource coordination, but a less-than-permanent “fix” with on-going maintenance funding.

Malaria remains the major chronic tropical disease in Western Equatorial Africa in general, and specifically in the region along the Congo river where Luozi, the territorial capital, is located. Institutions and initiatives that address this disease do not go beyond a general curative approach for each individual episode suffered. Fully a third of the populace is recorded to have visited a clinic for malaria each year in the past decade. Hospitals, health centers, health posts, and pharmacies all carry cure medications that bring down fever and help sufferers get through a particular episode. Infants suffering the dangerous combined effects of malaria infection – diarrhea, dehydration, anemia – are regularly given blood transfusions. Despite this ample medical response to endemic malaria, the disease is accepted as omnipresent in peoples’ lives. Malaria is considered a “normal” disease and the populace mostly accepts it as a given. WHO-distributed medicated nets were enthusiastically welcomed, and the nets may have somewhat lessened the infection rates. But they have in no way lessened the mosquitoes that carry and spread malaria. Thus, although the availability of cures offers medical institutions an aura of legitimacy in dealing with malaria, there is no engagement at the public level to change the status quo. This is evident in the malarial cures offered by private pharmacies, and the absence of public campaigns to lessen malaria infection. The same conclusion might be drawn regarding schistosomiasis along the rivers (it is chronic among fishing communities), and seasonal upper respiratory infections. The absence of a sustained public initiative on these major diseases is an indication of the lack of institutional legitimacy and the will to engage with these debilitating conditions.

By contrast, those diseases regarded as “dangerous” or “contagious” by international health agencies – HIV/AIDS, polio, trypanomiasis (sleeping sickness) – have all received focused attention and campaign funding in recent years. The WHO’s emphasis on maternal and child health has also provided special funds for the distribution of vitamin supplements to combat protein malnutrition in infants. Here the general demand or expectation of the populace has matched the INGO rational for the advancement of global health. The Health Zone has provided the format for carrying out these initiatives. But such initiatives have only gone part-way to the creation of health-maintaining infrastructure and long-term institutional legitimacy.

The appeal to the churches to take on the administration and coordination of the health zones in the early 1990s raises intriguing issues of legitimation. Clearly the will of the governed was engaged. The voices heard in “Unresolved remaining issues” suggest a groundswell of discontent, summed up in this comment: “the land is not thriving, there’s great difficult paying hospital and school fees. The government of the land should arrange matters to restore people’s hope.” Yet when the state fails, does the agency that comes forward to take its place find the legitimacy afforded a functional state, or even a state organized by patrimonial patronage ties? Dr. Monameso, head of the Protestant Department of Medicine (DOM), in both interview comments and in the Vision 2017 document voices serious doubts about this organization’s ability to meet expectations placed upon it. The funding base is unstable, insufficient to meet the need. He voices the concern that many clientele do not appreciate what the DOM is doing, the sacrificial service it is providing. Several medical doctors voiced their concern over the fact that the populace does not avail itself of the medical services it has available before it, but instead runs off to charlatan healers who offer panacea remedies instead of real medical care. Vision 2017 suggests that an advertising campaign might be needed to promote the Health Zone and its medical institutions. But the long-range plan represented by Vision 2017 suggests

that the heads of this organization and the church elders see this as a temporary solution. Restoration of state support and coordination is the expected norm. Yet the churches do have the confidence of most citizens, and the church bureaucracies were the most durable corporate structures remaining after the collapse of the state in the early 1990s.

The Health Zone framework itself is quite fragile in this entire scheme of divergent legitimations for public health and healthcare. Brought into existence in 1985, it now is the official structure within which to coordinate institutions, medical professionals, supplies and services. The small team of an animator, a nurse-infirmier, and a secretary was seriously challenged to visit all health posts on a regular basis. Locally, the citizen teams were doing their best to encourage nurses and other medical practitioners to meet the needs of the people. Yet the Luozi Health Zone team lacked even a single computer to compile its results, relying on large paper sheets on the walls of its small offices to tabulate participation rates, medication records, in addition to basic demographic and epidemiological information. The high expectations placed upon these teams by the populace and by the agencies expecting good records — e. g., the shadow Ministry of Health, the WHO — gave them strong legitimacy, hardly matched by funds to carry out their multiple tasks.

The importance of the need for a full range of legitimation anchors for these services to be effectively initiated and maintained. Public demand and expressed need for the service is but one aspect of the legitimation needed. The coordination of medical experts and institutional upkeep requires extensive legitimation of the kind that Weber called “rational-legal” authority. Yet the entire structure is kept together by an over-arching authority of the kind we usually associate with the state or other public authority. The churches of Congo, although clearly willing to carry out this extraordinary service of medical coordination, do not themselves find much satisfaction in doing this, the work of the state. They await fuller state “partnership.”

These failures of overarching state power and legitimation, and corresponding lack of funding, explain the continuing chronic levels of diseases such as malaria, tuberculosis, schistosomiasis, and inattention to the rising rates of seasonal flu. The success in bringing down protein malnutrition is due to a credible basic infrastructure of public health and special NGO attention to this condition, and financial support for the stocks of vitamins — full legitimacy at multiple levels of coordination and resource availability.

## Conclusions

The interplay of knowledge and power is pivotal to the achievement of effective control of disease and enhancement of health in the Manianga region of the Lower Congo, and in many similar regions across the globe. This work has focused particularly on the way that multiple kinds of knowledge have been developed to heal the conditions that affect many people in the region, and the social and institutional structures in which this knowledge has been couched. Of particular concern has been the process by which such structures acquire, maintain, or lose their legitimacy in the face of a history of decline of particular instances of public order. The argument I have made is that the evisceration of public authority — whether by global trade, colonial conquest, or corruption by postcolonial despotism — results in a kind of paralysis of public institutions, including healthcare. An analysis of the multiple and divergent health and healthcare institutions that responded to the collapse of state institutions has in particular

examined the manner in which the remaining and alternatively newly created institutions acquire their legitimation. The proposition has been put forward that such institutions, largely operating in a political vacuum, require a robust legitimation to achieve their goals to control or alleviate chronic diseases.

I have suggested in this paper that social legitimation—the public will, clear authority by duly elected or appointed officials, experts with adequate resources at their disposal—must achieve popularly desired goals of health care and public health. Creative individuals will continue to launch special initiatives and found institutions, but the burden of history suggests that effective action in any realm—transportation infrastructure such as roads, education, scientific research and development, food production, here health and healthcare—require longterm consistency can best be provided by an enlightened stable state, based on a constitution, accompanied by laws to guide it, incorporating an adequate educational system to produce the needed health and health care experts. That is the social legitimacy that the people of Lower Congo crave and deserve.

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