Targets of Salvation: Ovumuila Women with Tuberculosis and the Potential of the "Unreached" in Medical Mission

Rebecca Plett *McMaster University*

Abstract: The colonial history and political economy of Angola through years of conflict have marginalized the Ovumuila, a proportionately small ethnic group living primarily in the southwestern corner of the country. Yet it is precisely this constructed "backwardness" that has, ironically, rendered them targets of the contemporary colonialist enterprise of medicine and evangelical Christian mission. Drawing on ethnographic fieldwork at a rural clinic, this article discusses how Ovumuila women with tuberculosis are characterized as "unreached" and "at risk," thus providing the impetus for an incessant and penetrating agenda of salvation.

Keywords: tuberculosis, Angola, targets, medicine, Christianity, risk

Résumé : L'histoire coloniale et l'économie politique de l'Angola lors des années de conflit ont marginalisé les Ovumuila, un groupe ethnique relativement minoritaire habitant la région sud-ouest du pays. Or, il est ironique que leur présumé « retard » ou « isolement » soit précisément ce qui les a désignés comme la cible de l'entreprise coloniale contemporaine sous forme de missions médicales et évangéliques chrétiennes. À partir d'un terrain ethnographique dans une clinique rurale, cet article examine comment les femmes Ovumuila atteintes de la tuberculose sont caractérisées comme « à risque » et « non contactées », entraînant un programme des plus soutenus visant à assurer leur salut.

Mots-clés : tuberculose, Angola, cibles, médecine, Christianisme, risque

Introduction

The meaning accorded to tuberculosis (TB) as an illness has differed across time and space and is continually in flux, dynamic and reinterpreted daily. TB therefore is, and perhaps always has been, more than the sum of its bacterial parts, and it is currently becoming an increasingly problematic infectious disease worldwide. As Inhorn and Brown point out, "infectious disease problems are both biological and cultural, historical and contemporary, theoretical and practical" (1997:32). Yet the implications of such categorizations as they become lived necessitates attending to more complicated confluences—how bodies, illness and even treatments become metaphors of historically situated tropes, indexing forms of orthodoxy and orthopraxy through the contemporary salvific task of disease eradication. Encounters between practitioners of biomedicine and Africans (as a notable and monolithic target of the WHO's Stop TB campaign) are instructive in attending to these confluences.

In this article I take as exemplary the illness experiences of 12 Ovumuila women with TB who have chosen to receive treatment at a rural clinic in southwestern Angola. TB in post-conflict Angola is a considerable problem, reflected in the most recent WHO (2013a; 2013b) statistics that state the prevalence of the disease per 100,000 people to be 413, whereas the regional sub-Saharan African number is 293 per 100,000. The women I talked with about TB varied in age from 30 to 60 and in a variety of ways appropriate to their ages. All of them cared for large, extended families, cultivating crops or selling produce in nearby markets. Some stayed at the clinic's patient housing provided for those receiving TB treatment, and some walked the many miles to the clinic to receive medication every week. Yet their choice to seek treatment at the clinic allowed them to become enfolded within a complex mire of medicine and mission in which their Ovumuila ethnic label enables their transformation from an isolated rural people

viewed as "backward" to targets of medical and Christian conversion.

They are described as "unreached" by Christian missionaries, who consider their isolation as preventing them from hearing God's word, and "at risk" for TB by both the WHO and the clinic's medical staff, who implement infectious disease control programs in the area. What is more, the potency of these metaphors results from Angola's history, geography and spatial dispersion of Portuguese colonialist influence—which includes contemporary medical practice and evangelical Christian mission presence—whereby the Ovumuila have been consistently peripheral to any external agendas regarding resource extraction, economic development or the project of modernization. The irony, then, is that years of marginalization and historical dismissal of the Ovumuila by the Portuguese and, later, by "modern" and "assimilated" Angolans, enable the Ovumuila to be reclassified as targets of Christian mission organizations (as tantalizingly "unreached") and of the infectious disease eradication agenda of the WHO. This trope of "targetedness" cannot be understood without attending to its complex embedding within Angola's colonial history, its unique political economy, the effects of assimilation policies resulting from years of devastating war, and the situatedness of the clinic within medical discourses of TB.

Background

Within Angola, there are three main ethnolinguistic groups or clusters, which make up nearly 75 per cent of the population: Ovimbundu, Mbundu and Bakongo (Hodges 2004). The largest single ethnic identification in Angola is Ovimbundu, representing about 37 per cent of the population (Warner 1991). The clinic is situated in an area populated by the Nyaneka-Humbe (of which the Ovumuila are part), an ethnolinguistic grouping comprising only three per cent of Angola's total population and concentrated in Huila province (Warner 1991). The clinic is located in southwestern Angola approximately 40 kilometres south of Lubango, the capital city of Huila province, along the main highway connecting Lubango and Namibia to the south. The clinic is surrounded by several groupings of huts/houses comprised of family units and their corn fields. Supplies other than what can be grown or harvested on-site must be accessed by foot or taxi at small markets along the highway or at the bigger centres of Lubango to the north or Chibia to the south, both of which have government-run hospitals and clinics.

As it is a private clinic run by an evangelical mission organization, patients were charged for services. During my fieldwork in 2008, one doctor was on staff working three days per week, as well as a handful of nursing staff, ancillary staff and "TB specialists," the Community Health Team, who have received specialized training and education on TB. There are about 250 patients registered in the TB program each year. Because many patients travel great distances (often on foot) to receive treatment at the clinic and the treatment period is quite lengthy, temporary housing is available in proximity to the clinic, thus artificially increasing the population of the community.

The region of "southern Angola," of which Huila province is a part, maintains a sort of distinction from the rest of Angola; its unique history is imbricated in the area's particular ecology and geography, population distribution and shifting global markets; the Nyaneka-Humbe of southwestern Angola encountered the spectre of Portuguese colonialism less acutely than those in other parts of the country. Southern Angola has few natural or human resources, consisting of the northern marches of two deserts, the Namib and the Kalahari, separated by a formidable escarpment (Clarence-Smith 1979), while the northern regions of the country, in contrast, are resource-rich and distinguished by significant rainfall and forest. The escarpment is at its steepest to the west of Lubango, where the Huila plateau falls nearly 1,500 metres straight down to the coastal plain 150 kilometres from the Atlantic Ocean at the port of Namibe, nearly due west of Lubango.

The semi-desert coastal plain is sparsely populated, but above the escarpment, in the Huila highlands surrounding Lubango, higher rainfall allows for denser populations. The presence of this swath of semi-desert, the escarpment and the uneven distribution of population have meant that transportation and communication within southern Angola have, historically, been limited (Clarence-Smith 1979). Since their arrival on Angolan shores in the 15th century, the Portuguese stayed on the coast, building fortresses at strategic locations to facilitate the trade of Angolans to Brazil—Portugal's major colony in South America—to work on sugar cane plantations. Such was the case for the seaport at Namibe, from which transportation networks were restricted to northern and southern routes along the coasts and inland to the escarpment. Therefore, because of the geography of the region, the "colonial nuclei" of Portuguese settlements were restricted and discontinuous.

Wheeler and Pelissier (1971) suggest that up to four million Angolans were taken in the Portuguese slave trade, and military efforts to maintain control of such economic interests meant that between 1579 and the 1920s, scarcely five years went by without an incursion;

the history of violence in Angola has thus been nearly constant since the arrival of Europeans in the 16th century. When Brazil achieved independence from Portugal in 1822 and the slave trade declined, the Portuguese were forced to develop other economic interests to maintain control of their African colony (Wheeler and Pelissier 1971).

As a result, following the abolition of the slave trade, the Portuguese became increasingly attentive to the area inland from their port stations to develop further nationalist interests and to secure a Portuguese foothold on the continent, as other European colonial powers were intent on doing at the time. In particular, there emerged a vision of filling southern Angola with white Portuguese settlers and African slaves to secure the colony for Portugal. Around 1910 Portugal became further interested in the development of a plantation sector based on immigrant labour; this would involve the imposition of taxation and forced labour of Africans (Clarence-Smith 1979). However, both because of the process the Portuguese undertook to achieve these ends and because of the resource-poor landscape, the effects were not as grand as was initially hoped. The shifting cultivation practices of the African groups in the area meant that land was not settled permanently, resulting in the government letting white settlers take whatever land they desired, at its most extreme, suggesting that all Africans would be "exterminated" from the land anyway (Clarence-Smith 1979:80). Though this did not happen in actuality, all the most arable and preferable agricultural land was taken by white settlers.

Between 1920 and 1960, Angola went through an uncomfortable transition from subsistence agriculture to a market economy. A railroad-building rush led to the "opening up" of the interior of the country, its settling by Europeans and the creation of a plantation sector that allowed for the cultivation of coffee, cotton, sisal and corn for export (Newitt 2008). This also significantly altered the relationship of the Portuguese and Angolans, who were now being employed as plantation workers. Whereas the Portuguese had maintained a strong coastal economy through the slave trade with Europe and the Americas, cities in the interior were now being built and settled by European immigrants (Newitt 2008), while agricultural land was increasingly taken and used for growing exportable crops. In this emerging market economy, young adult Angolan men would find employment on plantations or in the cities, shifting the demographics and dynamics of families and social networks (Henderson 1979).

In the 1920s and 1930s, the economy of southern Angola was significantly affected by the Depression, resulting in the complete stagnation of the economy by the 1950s. In the 1960s, with insurrection beginning in the northern parts of Angola, the Portuguese became fearful of new peasant violence and concentrated on creating social and economic changes for Angola, particularly in the south (Clarence-Smith 1979). This meant an increase in health and education spending; increased communication and transportation, including airstrips and paved roads; and a new hydroelectric dam. Lubango doubled its population between 1960 and 1970 and became the main commercial and administrative centre of the province, over Namibe (Clarence-Smith 1979).

The changing economic landscape since the 1920s led to increasing urbanization; employment in the cities subsequently became competitive, imbued with tensions around race and power. As Clarence-Smith suggests, discrimination by European employers toward Angolans "was just one of the ways in which a section of the petite Portuguese bourgeoisie (fishermen, small farmers, petty traders) attempted to maximize their own security at the expense of others" (1979:57). To solidify this security, the Portuguese government in Angola developed an assimilation policy that followed the example of French colonialists in categorizing Africans. This categorization was based on the concept of

> assimilation ... that was meant to deal with the competition for urban employment between Africans educated in mission schools, the Afro-Portuguese (those Angolans with both Portuguese and African ancestry) and poor white immigrants ... To become an *assimilado* [someone who is assimilated] a person had to display stipulated levels of education, Portuguese culture and economic independence, criteria that could be raised or lowered to regulate admission into the colonial elite. [Newitt 2008:53]

Almost all Afro-Portuguese and nearly 50 thousand Africans were given assimilated status, forming a new educated elite, separated from the majority of the population. From this group came the leadership of the nationalist movements that would challenge both the Portuguese for independence and the Portuguese nationalist rhetoric supported by Western countries in the 1970s (Newitt 2008). If the Portuguese colonial mandate was as "racially tolerant" as postulated, why did no Angolans hold positions in either the public or private sectors and in the educational system, and why did forced labour, expropriation of African lands and arbitrary arrests and torture continue to exist (Bender 1978)? Somewhat ironically, as Newitt (2008) points out, the formation of an educated, elite, urban nationalist movement striving for independence nevertheless was a

continuation of the Portuguese colonial social distinction of "assimilated" that they were striving to overcome.

After several incursions, independence from Portugal was granted in 1975, but conflict escalated between factions vying for control. Over the course of nearly 30 years, various world powers were also involved (including Russia, the United States, Israel and South Africa), arming Angolan factions fighting first over the merits of communist ideology and later over oil and diamonds. The ethnic landscape of Angola changed dramatically after 1975 and during the nearly 30 years of war which followed. During these years, the population underwent an intensive urbanization process, which meant an unprecedented interaction of people of differing cultural backgrounds living in proximity, vying for employment and competing for the same limited resources (Hodges 2004).

The paradox of Angola within an economic framework, however, is its description as a country endowed the "richest" resources in Africa yet associated with years of conflict, economic decline and human misery, rather than with development and relative prosperity (Hodges 2004). Such assertions foreground the problematic tensions of capitalist promises of "development" and "prosperity" undercut by the dangers of resource "extraction": Until 2002 Angola was racked by conflict that began after its independence from Portuguese colonialism and was propagated through the exploitation of two of the West's most precious resources—oil and diamonds. As Renner describes, "the ideological differences that first sparked the war came to reside in the dustbin of history but resource-driven greed and corruption proved to be powerful fuel for its continuation" (2002:6).

In 2002, after nearly 30 years of conflict, the country was reeling from the collapse of its administrative infrastructure, and a bleak economic situation severely compromised any government support for social institutions. Chabal (2008), for instance, notes the interaction of certain factors, whose confluence can be seen to characterize the modern nature of Angola: years of Portuguese rule and its impact on the relationship between ethnic and regional groups, anticolonial and nationalist movements, and the effects of oil wealth. The result leaves postwar Angola with a chronic lack of educational materials and school books, and its hospitals lack sufficient medicines or equipment (Pearce 2005).

The UN estimates the number of displaced persons in Angola to be four million, and after the war ended, a major demographic shift occurred throughout the country to accommodate the movement of these persons (Ayisi 1998). This massive displacement of people, however, has meant that a national Angolan identity has developed instead of an "ethnic particularism," most evident with the prominence of the Portuguese language at the expense of African languages (Hodges 2004). The post-independence government adopted the Portuguese language as an instrument of national unity; therefore, it has been (and continues to be) the exclusive medium of educational instruction and the language of the military, subsequently providing a common language for generations of Angolan soldiers. According to Hodges (2004), nowhere else in Africa, with the exception of some island states, has a European language taken up a place of such prominence among the population, particularly owing to urbanization, the expansion of education after independence and the impact of television.

Yet, while this dramatic urbanization was occurring and the Portuguese were manoeuvring further toward Africa's interior, the Ovumuila seem to have been less interested in this project. At one point in the 1930s, in fact, they offered armed resistance to the European takeover of succession disputes, arbitration and judicial functions in Ovumuila communities, functions previously presided over by chiefs of clans. An organized group of "social bandits" formed, from within various Ovumuila tribes and clans, to abolish what they perceived as European interference. These bandits initially came from the hierarchy of chiefs of surrounding clans and tribes and were eventually joined by escaped slaves and ex-soldiers who assisted in building fortresses to attack the Portuguese. The organization eventually devolved and was defeated by the Portuguese, yet such a form of armed resistance (up until the conflict following independence) was unique in the historical relationship between Angolan groups and the Portuguese (Clarence-Smith 1979).

The war left the southwestern portions of the country (poor as they were in resources and subject to the exigencies of a difficult geography) relatively untouched; the assimilation project, too, was less successful, and greater numbers of Ovumuila tended to remain subsistence agriculturalists. Yet, as the Portuguese cultural influence was resisted to a greater degree by the Ovumuila, who tended to maintain traditional cultural practices and subsistence agriculture, they began to garner a reputation for a lack of sophistication and provincialism owing to what was perceived as a rather antimodernist position (Clarence-Smith 1979). In the literature on Angola's history of ethnic relations, there are references to the "cultural conservatism" of the Ovumuila (Clarence-Smith 1979; Warner 1991) or to their reputation in Angola as a "hopelessly backward and conservative people" (Warner 1991:103). Such ethnic relations were intimated to me by several clinic staff members, some direct, some rather more vague. One

response to the question of what makes someone Ovumuila and not Mbundu was answered with a knowing chuckle, a sound of hesitation, then "the language they speak is different." Further questions were unwelcome. Another stated, "The Mumuila are really looked down upon. Like they're less. Dirtier." Beyond the scope of interview scenarios, costuming, too, evinced boundaries: Staff members wore white medical coats over Western-styled clothing, while the women I talked with all wore Ovumuila-styled clothing, replete with elaborate beaded jewellery and hairstyles, colourful skirts and bare feet. This was commented on by staff members occasionally, stating that they (Ovumuila patients) "still" wear "those clothes," clearly not obtaining the status a "modern" wardrobe brings.

Ethnic Relations and TB

Such visual cues communicate a rich terrain of significance in understanding southern Angolan ethnic relations. The consideration that there were also non-Ovumuila *staff* members (and their white coats) is further significant as their medical training works potently to influence how patients are viewed. In the case of TB, biomedical practice is shaped by a metaphorical legacy of "consumption." Views of African bodies also figure prominently in WHO programming, working to render certain target groups—those more isolated, "poorer," perhaps even "dirtier"—as at increased risk.

As postwar Angola was struggling with a collapsed infrastructure following the war, rates of TB—as in most of Africa—began to rise. Globally, only AIDS is responsible for more deaths than TB, and the highest TB mortality rates are found in sub-Saharan Africa (WHO 2008). Recognizing the significant disease burden this places on sub-Saharan Africa's infrastructure at every level, the WHO has attempted to alleviate this burden through implementation of an intensive control program, in accordance with its goals to eliminate TB as a global health problem by the year 2050 (WHO 2008). TB also holds the rather unfortunate designation of having been responsible for more morbidity and mortality than any other bacterial pathogen worldwide (Corbett and Raviglione 2005; Roberts and Buikstra 2003), despite an overwhelming mid-20th-century optimism surrounding the effectiveness of public health measures and the pharmacological eradication of TB and infectious disease in general (Mayer 2000).

This historically situated spectre still looms large in biomedical programming around the globe, influencing how TB treatment is carried out and how individuals with TB are enfolded within biomedical discourse. The history of European colonialism in Africa is long. The creation of modern Angola, for instance, is situated in relation to both the political history of Portugal and the entirety of the colonial enterprise within the African continent. In looking particularly at South Africa, Jean Comaroff (1993) suggests, in fact, that this colonial history and ideology shaped the European view of the body (in relation to the African body) and the development of medicine and public health. Nineteenth-century European thinking focused on the male place in nature and the human species in relation to the rest of the world. Reason, it was supposed, uncovered "man's essence," or human nature, which separated human from object and human from animal (Comaroff 1993). Knowledge therefore lay in "man" himself: "The essence of life was in the unplumbed depths of organic being, to be grasped through the invasive thrust, the looking and naming, of the new biology" (307). This way of seeing, this "invasive thrust," equated with the body, was produced and reproduced in discourses about the "discovery" of Africa by European explorers (Comaroff 1993).

This exploratory endeavour by Europeans involved the creation of discourse around the "natural hierarchy" in which Africans were placed lower on the evolutionary ladder and thus closer to animals than white Europeans were. In Angola these ideas solidified the Portuguese colonial enterprise within the country. The Portuguese settlers, who felt looked down upon in Europe, came to Angola perceiving themselves as superior to the Africans, thus developing an entrenched and significant classist and racist legacy in their attempt to "maximize their own security at the expense of others" (Clarence-Smith 1979:57; see also Wheeler and Pelissier 1971).

At the beginning of the 19th century, European colonial officials sought to ensure the well-being of both government employees and the expanding European-majority communities. In South Africa (and Angola), the functioning of these communities was dependent on African labour. The contradiction of Africans being both central to the new colonial economy and yet marginal to its political and moral community was, according to Comaroff (1993), built into the constitution of South African society. The public health project to ensure the well-being of Europeans therefore also functioned to maintain control of Africans, situated within existing ideologies of colonialism and "man's place" within the natural order.

The African body, along with the whole of the African continent, was viewed as infectious and dangerous (Comaroff 1993; Schoepf 1998). Viewing Africans themselves as dirty was congruent with the idea that they were, in evolutionary terms, closer to animals than the white settlers. This is particularly the case for HIV and

AIDS in Africa because it is also entrenched within Western ideas of African sexuality. As Schoepf (1998) points out, biomedical accounts of AIDS in Africa are overtly racist, characterizing African sexuality, particularly that of women, as "promiscuous." In the global public health arena, these entrenched views of Africans are further evidenced by the sudden renewed interest in TB in the 1980s as a "re-emerging" infectious disease, though incidence rates had been climbing in certain geographical areas since the mid-century. TB in Africa—a disease of the poor and deprived—was thus not addressed in global health until the 1980s, when it became "problematic" in Western countries (Roberts and Buikstra 2003). Such labelling is an example of the metacommunication of biomedical discourse regarding African cultures and sexuality, and the idea of Africans being somehow dirtier (both sexually and as "impoverished") in contrast to Europeans has not been completely lost to history, nor has the popular early 20th-century idea that TB was a disease of poverty.

The metaphorical history of TB in Europe highlights myriad cultural values that become reflected in constructions of disease, like romanticism, capitalism and increasing urbanism and industrialization. Sontag (1979:5), in highlighting the role of both TB and cancer in our collective Western medical imagination, suggests that "the fantasies inspired by TB in the last century, by cancer now, are responses to a disease thought to be intractable and capricious—that is, a disease not understood—in an era in which medicine's central premise is that all diseases can be cured." Though TB dissolved the physical body, it "etherealized the personality" and "expanded consciousness" in death and led to a new sense of death as aesthetic (18). The "consumptive appearance," a physical measure of one's social worth, became a manner of "appearing"—appearing to not eat heartily and looking sickly for the sake of glamour. The "tubercular look" symbolized "an appealing vulnerability and a superior sensitivity," especially for women (29).

In southern Angola, though far apart in time and space from Romantic Europe, TB's effects on the body also opened space for metaphors of "consumption" but in different form. Present in all of the interviews and numerous informal conversations I had with staff at the clinic was an implicit description of a non-sick body, a body (particularly, that of a woman) that was able to fully participate in expected Ovumuila social relations and economic activities. This idea was evident throughout the women's narratives in talk of the appearance of the non-sick body. Most frequently and most explicitly, this was explained by the women as a decrease in strength, specifically the inability to walk or to walk long distances. When asked how they felt when they first knew they were "sick," most women responded with descriptions of a cough that would not resolve and weakness. One woman stated that she decided to seek treatment because "I couldn't walk ... and also, I had a big body, I was really big and strong ... but [not] now ... it's because of the sickness." Other women, in remarking about how they knew the medication/treatment was working, stated they were "feeling better" as expressed through a renewed ability to walk: "I'm feeling better because in the past I couldn't walk a long distance but now, I can walk a good distance."

For the Ovumuila, who are not reliant on cars and telephones for communication, it is no wonder that the ability to walk, to move one's body, was a prominent feature in the idea of what constituted a state of "abnormality"—of sickness. The the importance of a state of being "big and strong" was also echoed by others, who showed me the degree to which they had lost muscle on their arms, who declined requests for pictures because they were ashamed of their thin bodies or who frequently commented on how big and strong *I* looked.

Yet perhaps the most potent metaphors of TB are those from the beginning of the 20th century, when the medical treatment of TB began the sanatoria movement. This change shifted from treating TB with pleasing scenery and climate—a "change of air"—to treating it via institutionalized segregation. With the rapid industrialization and urbanization in North America and Europe, TB became geographically situated in poor locales. The metaphors about TB came to reflect the disease as a "disgusting stigma of poverty" (Gandy 2003:22). The imbrication of disease and poverty is certainly evident in contemporary TB programming and remains particularly salient for the Ovumuila, imbued as they are with the essentialist qualities of the "impoverished African" susceptible to or at risk for disease.

While life for these women is undoubtedly difficult, the processes that render them "impoverished," "at risk" or as "targets" work, in a Foucauldian sense, to transform them into the subjects that necessitate the salvific mission of medicine and of the evangelical Christian organizations who run medical services like this. The idea of poverty is an idea of development produced within the past 50 years, classifying these women as impoverished based on Western economic standards (Escobar 1995). Though it is true that the women interviewed had to work extremely hard, were worried for their families and often could not generate enough income to pay for the health care they needed, the problem, it seems, is not that these women are living in poverty

but that we have come to view these women as being impoverished and therefore at increased risk for developing TB.

The idea of medical surveillance and discipline put forward by Foucault and the critique of Western medicine's focus on health as a project of self-discipline enacted on the body and separated from the social or emotional (Crawford 1985) both allude to larger historically situated systems of colonialism and development (Comaroff 1993). Escobar (1995), for instance, offers that the same problematization of phenomena by First World experts functions within the processes of development and the creation of the Third World. The need for resources for the capitalist-industrial system that fuelled the superpower status of the United States after World War II required the creation of a "domain of expertise" to control and manage the resources of the rest of the world. Just as medicine as science was seen as objectively describing reality and therefore not influenced by social processes (Hepburn 1988; Martin 1989), development became an economic and market-driven enterprise that was based on objective scientific fact, ostensibly legitimating it because of its removal from the cultural context (Escobar 1995). So, too, does the WHO TB programming function, where the concerns of the First World provide the imperatives for action in international health work (Lane and Rubenstein 1996). Yet this one-size-fits-all approach encounters innumerable obstacles in its deployment, as efforts at the clinic can attest.

The centrepiece of such an international health strategy intended to control TB is the DOTS strategy (Direct Observation Therapy, short course). Initiated by the WHO and the International Union against Tuberculosis and Lung Disease in the early 1990s, the DOTS strategy is meant to reduce mortality, morbidity and transmission of TB worldwide by "directly observing" patients as they take their medications (Lewontin and Levins 2003; Lienhardt et al. 2003). Because the treatment of TB is based on lengthy, multidrug therapy, the DOTS strategy was developed as a means of assisting TB patients in following a regimen that includes taking four different pharmaceuticals for six months (Garay 2004). Further, the DOTS strategy focuses on five major components: government commitment to TB control, diagnosis including bacteriology with an effective laboratory network, short-course chemotherapy with a four-drug regimen, an uninterrupted supply of quality-assured drugs and the consistent recording and reporting of patients (Chauhan et al. 2005).

DOTS has not met with the success initially anticipated, however, and much literature (particularly in the realm of public health) is devoted to uncovering possible reasons for this. For instance, the issue of access to health care services is commonly raised in public health research and anthropological literature, as it relates to reasons why individuals do not comply with DOTS treatment regimens. It has been reasoned that if better chemotherapeutic agents were available—eliminating the need for lengthy therapy and combating the threat of multidrug resistance—issues of access and patient (non-)adherence, the most troublesome barriers to effective programming in this system, would be eradicated (Dye et al. 2006; Liefooghe et al. 1997; Pratt et al. 2005; WHO 2006a; WHO 2006b).

When examined in totality, the multiple barriers to proper TB control identified through different levels and perspectives of study move into tighter and tighter spheres of identification from the more general (like access and poverty) to more specific (patient adherence or consultation with traditional healers). Within the biomedical ethos, attempts are made to rationally assess why the implementation of a seemingly coherent control program is not functioning, most often focused at the patient level. Poverty and other socio-economic factors function on a larger access level, while practitioners of such a model enter into a patient–clinician relationship with cultural baggage and assumptions about the education levels of their patients and mistrust about patient compliance. In other words, treatment failure is the patient's fault.

The task of curing TB at the clinic, however, is frustrated by seemingly obdurate patients who refuse to seek the correct treatment or who default on it. The significant number of defaults (failure to "observably" take TB pharmaceuticals, resulting in a blank space on the patient's chart) was also a point of frustration. When asked why they thought so many patients had lapses in their TB treatment regimen, one nurse on staff with whom I spoke remarked, in rather exasperated tones, that patients say they forgot to come to the clinic or could not (would not) make the effort. With no phones and little contact information, the logistics of communicating the importance of continuing treatment to these deserters, or of reminding patients to come to the clinic, become quite complicated. The frustration regarding defaulting behaviour was also evident when patients with several weeks of unchecked boxes (defaults) on their medical charts resumed treatment. On one occasion, I witnessed a confrontation between a nurse and a TB patient. The nurse, waving the medical chart with its plethora of blank checkboxes, was quite forcefully castigating the patient for these defaults. The patient, meanwhile, stood rather meekly staring at the ground.

The frustrations expressed by the staff are understandable in the context of TB control; diagnosis and treatment based on DOTS would be simple and effective if all patients with TB followed the DOTS rules. The DOTS strategy requires unwavering devotion to treatment regimens and early voluntary case detection, meaning there is no room for flexibility in adhering to treatment. Phrased thus, such notions posit an implicit sense of responsibility in ensuring the success of the DOTS program. While several epidemiologically oriented studies place the responsibility of successful therapy on those supervising the care of the patient, because of the public health considerations related to TB (Hopewell 2006) or negligent care (see, for example, Buu et al. 2003; Squire et al. 2005), the majority, along with the staff at the clinic, place that responsibility, through education, on the patient. Simultaneously, such actions work to absolve the clinic and medical staff of any responsibility in the failure to eradicate TB.

Though this pharmaceutical regimen is effective in curing TB, certain people are necessarily targeted and chastised for not adhering to the orthopraxy of the control program as it is deployed. As the example of this particular clinic would attest, I would argue that it is those who fall into those WHO classifications—the impoverished and the provincial—who are foregrounded within its programming as its most potent targets. Such targeting is evident particularly in programming aimed at education, a potent index of medicine's orthodoxy and the necessity for conversion in getting subjects to believe the message and act accordingly.

From the perspective of the clinic staff, this process of conversion was an undertaking fraught with difficulty. There seemed to be a general frustration with the length of time it took for individuals with a cough to come in to the clinic, a frustration shared by many medical practitioners involved in TB programming and public health initiatives in Africa (Montgomery et al. 2006). One nurse suggested explicitly that what needs to happen is more education, as people generally do not realize a persistent cough could be significant and require treatment. Frustration was also expressed at the lingering idea that TB is caused by witchcraft, a belief which leads individuals to seek treatment from witch doctors. Such treatment may exacerbate the problem, cause other problems, or have no effect but to delay proper treatment, all of which impact on the health care provider and absolve the clinic and clinic staff of responsibility for treatment failure.

The women's ways of incorporating such "educational efforts" proved fascinating. Over the course of my fieldwork, what became increasingly apparent was the hybridity of causal explanations of TB provided by the Ovumuila women with whom I talked. TB information—what it was, how to treat it, what precautions to take to prevent contagion—was relayed by health care workers following diagnosis. When I inquired after what information was gleaned following such an information session, all of the women responded with a list of proscriptions reflective of the biomedical interest in preventing behaviour that may lead to infection of others. Interestingly, when a few women were asked directly, "What did [this nurse] tell you TB is?" one woman responded, "They told me that I had TB, that I had a cough, which is TB." She then went on to list the things she was told not to do. The other women mentioned nothing about "what TB is," but rather only what the health care staff told them to do or not to do. The women did not refer to themselves as having TB, instead stating they were either told their cough was TB or relied on the health care staff to give them information. Two women, for example, stated they were told to eat healthy food and not drink alcohol; what "healthy food" was, specifically, was not mentioned. One woman stated she was told not to eat dried fish (a rather common food staple), although she expressed uncertainty (or even apathy) as to why not.

In addition, while several women mentioned they were not supposed to eat with others or share utensils like cups or spoons, one woman said that she was told she could eat with her family. Most women offered further variations on how to "prevent the spread": cover their mouths when coughing, do not cough on others, and if you have to spit on the ground, cover it up or use a cup so that you can dispose of the contents. Sometimes this was understood as necessary, to avoid infecting others, but not consistently—the woman with extrapulmonary TB was not contagious (i.e., did not have pulmonary involvement) but still understood she was not supposed to cough on others and should cover her spit. Such efforts at education by medical staff, however, seem to engender divergence between the educators and those being educated, where disparate views of the power and authority of certain forms of knowledge, coupled with the requirement of conversion, work, in part, to entrench views of the backwardness of Ovumuila patients.

Medical education and its concomitant financial benefits become powerful indices of the desire for the "modern" in post-conflict Angola. At the clinic, the mission of both its evangelical mandate and medical agenda can therefore be seen to be centred on education—the orthodoxy required to successfully "save." I would argue, along with Good (1994), that "correct belief" is of central

concern to science and the Christian mission effort in Africa. Belief is enabled through conversion and, as John and Jean Comaroff (1992) suggest, a reformulation of consciousness that results in ultimate salvation. The task of both missionaries and public health workers is to get people to believe (and subsequently do) the right thing, and if this task is accomplished, public health problems like TB will presumably resolve. At the clinic, the potency of this enterprise is such that a Community Health Team roves the countryside, "penetrating" further into the communities of the unreached. The Community Health Team, whom I accompanied on numerous missions, comprised up to four (non-Ovumuila) staff members. We drove through the scrub and bush to designated meeting spots, being met by upwards of 50 adults and children, who, following a short sermon and prayer, were vaccinated, weighed and given vitamins. The crucial mission of these teams, however, was to identify possible cases of TB to be registered. Individuals with suspected TB were then sent to the clinic for treatment.

While the impetus for such health teams is to bring the "message" that the Ovumuila should believe in the power of germs and their own sinful nature (understood to manifest itself through faith in traditional knowledge and in witch doctors or spirits, for instance) in order that they may receive salvation through medical mission practice, the translation of that message to action is less clear. When I asked why the women came to be treated at the clinic, all responded by explaining they had a social connection with a staff member. One woman, for instance, explained that her husband's brother is a neighbour to one of the nurses at the clinic. When the time came for the family to decide how to remedy the woman's increasing weakness and worsening cough, they chose the clinic because they knew someone who worked there, rather than (most tellingly perhaps) going to a government-run hospital where services were *free*. At the same time as public health researchers, epidemiologists and social scientists research reasons why TB continues to plague sub-Saharan Africa or why education programs are not functioning as efficiently as planned, here is a powerful example of how relationships function to relieve these women's afflictions in ways that feel appropriate to the Ovumuila, regardless of their perceived disease etiology or the ways such explanations may differ from the perceptions of the staff members who treat them.

Can this then be tenuously framed as a sort of resistance, a "consciousness of colonization," as John and Jean Comaroff (1992) suggest, a resistance to the inculcation of the promise of salvation, of cure, imported by evangelical missions and medicine? The Comaroffs cogently demonstrate the colonization of consciousness within southern Africa through the imposition of a European way of seeing and being, and signs and practices, by conversion. They argue that the effect of such conversion discourse was that, regardless of the outcomes of such attempts at persuasion, Africans were drawn into encounters whose terms were set by Europeans. The "drawing in" of the Ovumuila into the discourse of medicine and mission through intensive and penetrative control programming in this way remains negotiable, however, becoming a fascinating imbrication of notions about where or what TB is and how, where and from whom to find a solution for its debilitating effects.

The relative isolation of the Ovumuila in southwestern Angola has, ironically, made them, quite literally, targets. They are targeted as "unreached" by the evangelical Christian mission organization and as "at risk" for developing TB because of their poverty and isolation, according to the WHO. Through this categorization, they are dually rendered "docile bodies" in the Foucauldian sense, providing the impetus for the incessant and penetrating mission of medicine in an increasingly globalized postwar economy. "At risk" in this sense is fascinating: at risk for TB, yes, but perhaps further representational of yet a different sort of consciousness of colonization by the WHO, a realization of the potentiality—the risk—of resistance. This would be a risk of significant proportion to the mandate of infectious disease eradication and the mission of the evangelical church for whom human souls may be ultimately unreachable. If the Ovumuila are, in fact, at risk—at stake, even—what it is that they are at risk *for* remains to be seen.

Rebecca Plett, Department of Anthropology, McMaster University, 1280 Main St. West, Hamilton, Ontario, L8S 4L6, Canada. E-mail: plettra@mcmaster.ca

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